Maternal and Child Health Services
Title V Block Grant

State Narrative for Indiana

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are kept on file at the Indiana State Department of Health both in the Finance Department and in the office of the MCSHC Grants Coordinator with the hard copy of the grant application. They are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The State Title V program solicited public comments for this application by placing an Executive Summary of the FY 2006 application on the MCSHC web page. The web page provides the public an opportunity to review the Executive Summary and provide comments. After MCHB review, access to the entire application is also provided on the website. Copies of the Executive Summary were made available upon request and were also accessible in government document sections of thirteen public libraries across the state. A legal notice was placed in all major newspapers in the state alerting readers to the placement of the documents.

ISDH posted the 2007 application summary on the MCSHC web page and distributed the summary and the application electronically to the membership of the various MCSHC advisory committees and to all public libraries in the State. All public comments are recorded along with ISDH MCSHC response and all comments and responses are used during the preparation of the application for the following year. ISDH will announce the web location of the executive summary by legal notices placed in all major newspapers in the state.

Beginning with the FY 2007 application, MCSHC is making narrative sections of the application available to an advisory group and requesting input via e-mail.

/2008/The FY2008 application summary was sent electronically to the membership of the advisory committee to MCSHCS. MCSHCS received twenty two comments and several changes were made based on the suggestions. The application and an executive summary will be placed on the MCSHC website.//2008//

/2009/ For the FY2009 Title V Block Grant Application the State Title V program solicited public comments from their Advisory Panel. The Advisory Panel, made up of more than 100 members, reflects representation from the following types of organizations: Local Health Departments, Hospitals, Community Health Centers, the Department of Family and Children, Indiana Coalition Against Domestic Violence, Indiana Primary Health Care Association, Department of Education, Division of Mental Health and Addictions, Title X, the Bureau of Child Care, March of Dimes,

National Association of Social Workers, the Minority Health Council, Healthy Mothers Healthy Babies, and parental support groups and other groups representing the general public.

All panel members received an application summary electronically for their review and were encouraged to respond to any areas that fell under their field of expertise. Panel members from Title X's Indiana Family Health Council, the Health and Hospital Corporation-Marion County Health Department, MCH's Johnson Nichols's Health Clinic, Tri-Cap of Dubois/Pike/& Warrick counties Economic Opportunity Committee, 1st Steps, Clarion Hospital, Community Hospital East, and the Department of Education all responded with general comments. Their comments covered typos, suggestions for future inclusions, and overviews of what their specific projects were engaged in as related to the National and State Performance Measures. In response to this input, three changes were made to the Executive Summary section on National and State Performance Measures. Both the Application and Executive Summary will be placed on the MCSHC website as in past years.//2009/

/2010/ For the FY2010 Title V Block Grant Application, the State Title V Program solicited public comments from the Advisory Panel and repeated the process as detailed in FY2009 above. In addition, copies of the Preliminary Title V Block Grant Report were sent to all our Indiana Community Health Centers, Maternal and Child Health grantees, and all Indiana County Health Departments for comment. Copies of the Preliminary Title V Block Grant Report were also sent to 123 libraries throughout the state, with plans to post the report, and actual grant on the MCH Website for ongoing comment solicitation. All comments will be reviewed for potential inclusion into the present and future grant submissions. As of July 13, a few comments had been received and incorporated into this application.//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Summary of Needs Assessment for the Block Grant 2008

Since the submission of the FY 2006 Needs Assessment and the FY 2007 update, Maternal and Children's Special Health Care (MCSHC) Services has continued to focus on improving perinatal outcomes particularly those related to alcohol, tobacco, and other drug use statewide and by county. Assessments have been completed or are in progress which will assist MCSHC staff in educating local communities about problems and in developing local intervention plans to impact and improve national and state performance measures. (Please see the Needs Assessment Attachment to the grant application for specific highlights of the data and recommendations of the studies).

During FY 2007 additional statistical analyses were completed based on Vital Statistics data. Trends in Birth Outcomes in Indiana Counties--Statistics from Live Birth Data from 1990-2004 was published in March 2007 and Trends in Birth Outcomes in Indiana--Statistics from Live Birth Data from 1990-2005 was published in May 2007. Smoking During Pregnancy in Indiana, 1990-2004, Statistics from Live Birth Data was published in September 2006.

The first two studies present statistics on time trends in low birth weight, preterm birth, selected maternal characteristics and a variety of delivery methods (including cesarean delivery rates) by race and Hispanic origin of the mother over time as reported on birth certificates, according to the mother's Indiana residence at birth. The latter focuses on prenatal smoking statistics and includes the impact of urbanization on prenatal smoking.

Alcohol, Tobacco and Drug Use by Pregnant Women in Indiana was published September, 2006. This study was requested by the Indiana legislature. The purpose of this study was to collect information that would improve the understanding of the size of the problem of alcohol, tobacco, and drug (ATOD) use by pregnant women in Indiana; to determine the barriers, perceived or real, that keep pregnant ATOD users from getting needed treatment; and to suggest strategies that could be undertaken to improve the access to treatment services.

A Consensus Statement on Substance Use Disorders and Pregnancy was published in March, 2007. It was facilitated by the Indiana Perinatal Network, Inc., a Title V funded grantee which assist MCSHC in infrastructure building and policy development regarding perinatal health. These two external documents supported by the statistical trends provide recommendations for intervention.

With these statistics and assessments, the information gathered in the Community Forums and focus groups in the last two years, needs assessments, and recommendations, MCSHC has begun holding community disparity summits in five counties that focus on reducing disparity in perinatal health to engage and empower local groups to implement activities to impact ATOD use and other issues that inhibit access to care and impact poor outcomes of pregnancy. In addition, presentations for providers on tools to use to assess and intervene with pregnant smokers are being presented in five of the more rural focus counties and MCSHC is partnering with Indiana Rural Health Association to provide training in physicians' offices in five southern counties with the highest rates of smoking among pregnant women, as mentioned in the Title V grant application.

In recently published reports and state rankings related to access to care (insurance coverage and the state Medicaid program), Indiana was determined to be "mediocre" in number of uninsured and "poor" for Medicaid program qualities (eligibility, scope of services, quality of care and provider reimbursement). In the Robert Wood Johnson's Cover the Uninsured report distributed during the Cover the Uninsured Week, April, 2007, the State Profile for Indiana (based on 2003 data) reveals that 14.2% of Indiana's population and 9.0% of Indiana's children are uninsured. Based on 2004 and 2005 Medicaid data from Kaiser Family Foundation's Commission on Medicaid and the Uninsured and other data gathered and reported by Public Citizen, Indiana's state Medicaid program was ranked as one of the 10 worst programs in the nation. These rankings should change with recent legislation to expand Medicaid and health insurance coverage to families up to 200% of FPL and SCHIP coverage up to 300% of FPL. /2009/Indiana is in need of improvement in all the areas outlined in the FY09 Needs Assessment Update which is attached to the EHB. Indiana has a higher prevalence than the nation for children with asthma. Rates for SIDS and SUIDS have decreased in Indiana, but still need to continue the decline. Indiana has decreased in the percentage of short interpregnancy intervals over the past three years, but is still above the national average. Gestational weight gain and pre-pregnancy weight of women in Indiana will be analyzed in the next fiscal year.

The Youth Risk Behavior Survey shows a few disturbing trends in Indiana. The rates of alcohol and drug use, self-inflicted injury and suicide, and students having sexual intercourse all increased. Smoking prevalence in students has decreased, but is still much higher than the national average. Physical activity and weight and nutrition have shown signs of improvement, but much more progress is needed in these areas.

The National Survey of Children with Special Health Care needs shows that Indiana is behind Region V and the nation in many areas. Indiana has a larger percent of children with special health care needs than every other state in Region V, and the nation. Indiana is consistent with the nation in most of the core outcomes, but still needs to improve in many areas of children with special health care needs. See the Attachment File//2009///***2010/ Since the submission of the FY 2006 Needs Assessment and the FY 2007, 2008 and 2009 updates, Maternal and Children's Special Health Care (MCSHC) Services has continued to focus on improving multiple public health outcomes particularly those related to trends in preterm birth, cesarean delivery, and induction of labor in Indiana; along with other outcomes such as infant mortality, low and very low birth weight, smoking and drinking while pregnant and asthma. Assessments have been completed or are in progress which will assist MCSHC staff in educating local communities about problems and in developing local intervention plans to impact and improve national and state performance measures. The following attachment is a summary of the analysis that has occurred in the last fiscal year and has not previously been reported.//2010//***

An attachment is included in this section.

III. State Overview
A. Overview
Section III. State Overview

A. Overview

Indiana elected a new Governor, Mitchell E. Daniels, Jr. in 2004. Governor Daniels appointed Dr. Judith Monroe as the State Health Commissioner and Medical Director for Medicaid, the first woman appointed to head the health department and the first person to hold both positions simultaneously. Dr. Monroe's background is Family Practice Residency Training and Primary Care.

PRINCIPLE CHARACTERISTICS of STATE HEALTH NEEDS
Population -- 6,195,643
Statewide, Indiana's population grew by about 3 percent between 2000 and 2002, with most of the growth coming from more births than deaths and people moving to the state from other countries. Indiana grew at a slightly faster pace than neighboring states from 2000 to 2003, but well below the fastest growing states such as Georgia, Nevada and Idaho, all above 7%. /2008/ Indiana's population in 2005 was 6,271,973. With the 24th highest population growth rate among the states in 2005, Indiana continued to grow at a slightly faster pace than neighboring states with the exception of Kentucky.//2008//
Source: http://www.incontext.indiana.edu/2006/january/3.html/2009/Immigrants make up a much smaller share of Indiana's population than in the country as a whole. While 12% of the population of the United States (US) was born elsewhere, only four percent of Indiana's population is foreign-born, ranking the state 35th among the 50 states and the District of Columbia. On the other hand, the state ranks 12th in the percent change of its foreign-born population since 2000: this population grew almost 30 percent from 2000-2005, compared to a growth of the foreign-born population for the US as a whole of 16 percent during this period. Source: www.sipr.org/PDF/Indiana Immigration and Workforce Patterns.pdf//2009//
/2010/Between 2005 and 2007 the total number of live births to Indiana residents has risen 3%. (2005 was 87,088 then increased 2.7% in 2006 to 89,404 then increased .3% to 89,698 in 2007.//2010//

Hundreds moved out of Madison County between 2000 and 2004. Between 2001 and 2004, manufacturing jobs in Madison County dropped from 9,781 to 7,180. Henry, Grant, Wayne, Randolph and Rush counties in east-central Indiana also experienced population declines after the loss of manufacturing jobs. Widespread population loss also occurred in Newton, Vermillion, Knox and Posey counties along the Illinois border. The drops in Vermillion and Knox are attributed to deaths outnumbering births./2007/Madison and Grant Counties lead the state for manufacturing job losses from 2001 - 2005. These counties industries are very reliant on General Motors. Other counties with high manufacturing job losses include White, Fayette, Johnson and Wabash Counties.//2007///2008/ Honda announced plans and began building a new automotive facility in Decatur County. Population growth in Indiana continued to move out to areas surrounding the metropolitan centers of Indianapolis, Chicago, and Louisville while the major cities in Indiana did not experience significant population growth. //2008// /2009/According to the U.S. Bureau of Labor Statistics, Indiana's estimated unemployment rate in May 2008 had grown to 5.3 percent, compared to a rate of 4.4 percent in May 2007. //2009//
/2010/Unemployment continues to grow in Indiana at a high pace, with the latest US Labor Statistics compiled by 538.com showing an additional 3.5% growth from November through May, bringing Indiana's total unemployment to 10.8% as of May 2009.//2010//

Whites make up 89% of Indiana's population. Approximately 8.5% of the state's population is Black. Marion County (Indianapolis) and Lake County (Chicago area) have the highest

concentrations of African Americans, representing 24%-25% of each county's population. Other counties with urban centers and manufacturing job concentrations also have significant numbers of African Americans, the next highest being St. Joseph, Allen and LaPorte Counties at 10%-12% of their population. /2008/African Americans are about 8.4% of Indiana's population. Roughly half of Indiana's African American high school graduates enrolled in college in 2005.//2008//

The Ku Klux Klan has resurfaced across Lake, Porter and LaPorte Counties and was implicated in the burning of a house being built for a black family in Lake Station. The City of Gary has started community meetings to address recent racism. /2008/Indiana is one of 19 states identified by the Anti-Defamation League as having notable growth in KKK activity.//2008//

At 1.2% of Indiana's population, Asians are the fastest growing minority with the highest concentration at 4.5% in Tippecanoe County, home to Purdue University. Monroe and Hamilton Counties also have more than 2% Asian representation. Numerically, the greatest concentration of Asians is in Marion County (12,325 = 1.4%).
/2008/Asians remain the fastest growing racial demographic in Indiana, experiencing a population growth of more than 19% from 2000 to 2005.//2008//

The largest increase among Indiana's population has been the Hispanic ethnic group. Hispanics make up 3.5% of the state's population with the greatest concentration in Lake County, representing 12.2% of the population. The next closest county is Elkhart at 8.9%. Other counties that show the largest growth in Hispanic population include Marion, Allen, Tippecanoe and Porter. The influx of Spanish speaking people has caused hospitals, clinics, public safety and educational institutions to train personnel in Spanish language and Hispanic culture.
/2008/ Hispanics made up 4.5% of the population in 2005. The Hispanic population in Indianapolis more than tripled from 1998 to 2004, making them the fastest growing demographic in the city. This increase is a product of an influx of Hispanic residents and a baby boom among this population. //2008// /2009/According to the Center for Urban Policy and the Environment at IUPUI (Indiana University Purdue University at Indianapolis), Hispanic births in Indianapolis increased 422 percent between 1997 and 2004 (from 468 to 1,977 births), a change that affects child-care providers and schools. In school year 2004-2005, an estimated 9,900 HIspanic children were enrolled in Marion County schools, 7 percent of the total enrollment.//2009//
/2010/ In 2007, the Hispanic population is approximately 5% of the Indiana population. In 2007, 9.8% of all live births to Indiana residents were Hispanic. (8,788 of the 89,968 births were Hispanic with 315,089 Hispanics out of the total population of 6,345,289)//2010//

The second fastest growing minority population in Indiana is the Amish, with populations expected to double in 20 years. Concentrated in the northeast corner of the state, Indiana's Amish face unique challenges. The Elkhart-LaGrange settlement is the 3rd largest in the U.S. and while the U.S. Census does not track Amish populations, local estimates show about 3,300 school age (1st-8th grade) Amish children in the Elkhart-LaGrange settlement. According to estimates developed by Indiana University of Fort Wayne through the Amish Youth Vision Project, the total Amish population could be as high as 45,000 in this part of the state. An unusually high percentage of this population works in local factories -- more than 40% of Amish men.

During late teen years through their early twenties, Amish youth are not required to join the church and are not bound by its teachings. This tradition, known as Rumspringa, grows from the belief that Amish must join the church of their own free will. However, as documented in "The Devil's Playground," a video documentary prepared for the Public Broadcasting System, this population, particularly young Amish men are extremely vulnerable to drug use and other illegal and occasionally violent behavior -- particularly for factory workers who, unlike the Amish working in farming and small business, have free time, low cost of living and significant disposable income. Population increases and limited land availability put additional pressures on the Amish

as their larger communities grow to several times the traditional settlement size./2007/The Amish population referred to is the Old Order Amish. The estimates of population were developed by Steven M. Nolt Ph.d. and Thomas J. Meyers Ph.d. of Goshen College. The Amish Youth Vision Project funded primarily through ISDH, focuses on drug and alcohol education in hopes to reduce usage among Amish youth. One conference for law enforcement dealing with responding to Amish youth has been held, and a second conference to include mental health/social service providers is planned for the fall of 2006. A counseling group is providing drug and alcohol classes exclusively to Amish youth led by Amish leaders. Other Amish communities are now requesting assistance to implement their own programs.//2007//
/2008/Due to budget constraints, ISDH ended support for the Amish Youth Vision project in FY 2007, one year earlier than anticipated. Fortunately, the program has been funded by the Dekko Foundation. The project has now trained hundreds of police officers in ways to work more effectively with the Amish population to curb drug crimes among Amish youth. The project has also been very effective with involving and facilitating leadership within the Amish community. The bishops and elders now take the lead role in organizing the education for parents in more effective ways to help their adolescent and adult children through Rumspringa.//2008//
Source: Amish Youth Vision Project 2006 annual report to ISDH and Dekko Foundation

American Indians are one of the smallest minority groups in Indiana, making up 0.6% of the state's population, trailed only by Pacific Islanders at 0.1%. This population is scattered across the state. Only three counties, Marion, Lake and Allen have total American Indian populations of more than 1,000. Most counties have fewer than 100.
/2008/ Indiana's American Indian & Alaskan Native population grew by 6.4% while the population of Native Hawaiians & Pacific Islanders experienced a growth rate of 18.7% between 2000 and 2005. This population is so small, that the actual change in population during that period was an additional 539 persons.//2008//
Source:
http://www.stats.indiana.edu/stats_dpage/dpage.asp?id=72&view_number=2&menu_level=&panel_number= Select Indiana, 2005, Overview Race

While Indiana's labor force grew, employment levels steadily decreased from 1999 to 2003, causing a jump in the unemployment rate from 3% to 5.1%. This current unemployment rate is below average for the Midwest region. Kentucky has the lowest regional unemployment rate at 4.5%; Michigan has the highest at 6%./2007/Indiana's current unemployment rate is 5.0%, slightly above the 4.88% average for the Midwest. Minnesota had the lowest rate at 3.7% and Michigan the highest at 6.0%. The national average is 4.6%//2007//
/2008/Indiana's unemployment rate in November 2006 was 4.8% equal to the Midwest regional rate but above the national rate of 4.5%.//2008// Source: http://www.bls.gov/lau/home.htm Target = Unemployment Rates, seasonally adjusted. /2009/ Between the third quarter of 2001 and 2005, Indiana added 26,688 health care and social assistance jobs--a gain of 8.3 percent. This was the largest growth on a numeric basis and the second largest from a percent basis (trailing the administrative, support and waste management sector, whose growth exceeded 16 percent). Of the state's 92 counties, 73 experienced growth in the number of jobs in health and social assistance. Focusing on percentages, the largest increases occurred in Newton, Owen and Hamilton counties, and the largest declines were found in Jennings, Union and Rush counties.//2009//
Source www.incontext.indiana.edu ***/2010/The Indiana economy has fallen short of the U.S. economy over the past five years with respect to both personal income and employment. From the beginning of 2004 through the fourth quarter of last year Indiana per capita personal income has risen by 16.2%, while the national value has gained 21.9%. As a result, the ratio of Indiana per capita income to the national value has declined over four points (from 90.3% to 86.7%). The difference amounts to about $1700 for every person in the state. Low population growth plays a role in the slower growth of employment in Indiana relative to the nation, but this is less a factor during a contraction. Since the bottom dropped out of the labor market at the end of 2007 Indiana employment has***

declined by 4.2% compared to a 3.1% loss nationally. In the first quarter of 2009 Indiana employment contracted at an 8.4% annual rate versus the U.S. rate of 5.9%. Our employment forecast for May 2009 is substantially below that in February 2009. The difference results mainly from the first quarter data, which was weaker than our February estimate. Employment continues to drop through the end of this year. At that point total job loss approaches 200,000 (6.6% of pre-recession peak employment). Since the third quarter of 2007, Indiana employment has been declining at a rate of 88,000 per year. For comparison, during the period 1991-2006, the state economy gained an average of almost 29,000 jobs per year. To summarize: the Indiana economy has been losing ground relative to the U.S. as a whole, and our forecast is that this discouraging pattern will continue. Especially with regard to employment, the recession will continue to hit Indiana hard over the rest of this year. Economic woes and high unemployment rates continued to plague Indiana. With an unemployment rate of 18 percent in February, the Elklhart-Goshen area in Northeast Indiana had the highest annual increase, up 12.5 percentage points, in the nation. This area leads the nation in unemployment due in part to the decline of the recreation vehicle industry. //2010// Source www.incontext.indiana.edu and Indianapolis Star April 1, 2009.

Between 1999 and 2002, Indiana's poverty rate increased from 8.7% to 9.6% - still below the national average of 12.1%. The U.S. Census estimated in 2002 that 11.9% of Indiana's children live in poverty, with a higher rate of 14.5% for children under age 5. In Indianapolis, approximately 15,000 people are homeless in any given year, and an additional 45,000 people are in a housing crisis./2007/The 2004 single year poverty rate estimate for Indiana is 11.6%. For children, the poverty rate in 2004 was 18.5%, higher than the national average of 17.8%.//2007///2008/The Kids Count Data Book by the Annie E. Casey Foundation shows 12% of the population in poverty with 20% of children under age 6 in poverty in 2005.//2008//

Indiana requires impoverished families to pay income tax. Currently, families begin paying state income tax when they earn 76% of the federal poverty level. This tax threshold could be lowered to 36% if the state Earned Income Tax Credit is not upheld for 2005. Specifics can be found at the Center on Budget and Policy Priorities - http://www.cbpp.org/4-12-05sfp-in.pdf /2007/Indiana's threshold for families paying the state income tax remained the same in 2005, but the poverty level was increased, with the effect that families now begin paying state income tax when they earn 74% of the federal poverty level.//2007//

The Robert Wood Johnson Foundation (RWJF) used data collected by the Centers for Disease Control and Prevention to estimate that in 2003, there were more than 600,000 (16.3%) uninsured adults ages 18 to 64 in Indiana. The U.S. Census estimates the national uninsured rate at 13.9%. In 2003, 161,815 (9.6%) children in Indiana under age 19 were uninsured./2007/RWJF estimated that in 2004 14.2% of all Indiana residents did not have any insurance. For children under the age of 18, the uninsured rate is 8.9%. //2007///2008/U.S. Census data shows that in 2005 14.2% of all Indiana residents did not have any insurance and 9.7% of children under the age 18 were uninsured. In April the Indiana Legislature approved House Enrollment Act 1678 on health coverage for uninsured Hoosiers. The Act would raise the state's cigarette tax by 44 cents to help fund health coverage for 132,000 uninsured Hoosiers. The governor signed this legislation. //2008// ***/2010/Ann E. Casey Kids Count report shows that for 2007 the percentage of children under 17 without health insurance was 9%.//2010//***

Indiana ranks 46th for the percent age 25+ with BS, BA or graduate degrees at 21.1%. The state's economy still is based heavily on manufacturing. College graduates tend to leave the state for better pay. Indiana University is proposing a 4.9% tuition increase for undergraduate courses. The increase would cost undergraduates as much as $335 more in tuition and mandatory fees per semester. Purdue University is considering a 6% hike that would cost undergrads $366 more./2007/Latest estimates show a marked improvement in college graduation rates for Hoosiers age 25 and older. With a rate of 26.3% in 2002, Indiana ranked 34th. Indiana University

approved the 4.9% tuition fee increase in 2005. Purdue University adopted the proposed 6% hike.//2007//
/2008/The Indiana Department of Education revised the formula for determining high school graduation rates which show only 75.5% of high school students graduate statewide. The educational attainment rate for a Bachelors Degree or higher for Hoosiers age 25 and older was 21.1% in 2004.//2008//

In 2004, State Police alone arrested more than 1,200 people as a result of methamphetamine lab busts -- which affected the lives of at least 219 children, most of them related to the arrested adults and subsequently, thrust into the state's child protection system. Last year, state officials estimated, more than 30 percent of neglect and abuse cases they handled were in some way connected to methamphetamine abuse or manufacture. New legislation requires cold medications containing components used in methamphetamine manufacture to be controlled by pharmacists from behind the counter./2007/Methamphetamine lab seizures in Indiana decreased from 1549 in 2004 to 1300 labs seized in 2005.//2007///2008/ Heroin use is increasing in Indiana, State Police will have investigated about 700 cases in 2006, about 3 times the total in 2004.//2008//
/2009/Indiana is an active drug transportation and distribution area. The northern part of Indiana lies on Lake Michigan, which is a major waterway within the St. Lawrence Seaway system, providing international shipping for all sections of the Midwest. Seven interstate highway systems and 20 U.S. highways provide interstate and intrastate links for drug trafficking, especially with the southwest border and California. Highway (automobile and trucking) and airline trafficking are the primary means of drug importation, with busing systems as a secondary means. Mexican criminal groups are the primary wholesale distributors of marijuana, powdered cocaine, and methamphetamine within Indiana. 2007 Federal Drug Seizure In Indiana: Cocaine: 90.9 kgs., Heroin: 1.6 kgs., Methamphetamine: 13.1 kgs., Marijuana: 271.0 kgs., Meth Lab Incidents: 564 (DEA, state, and local) State Facts: Population: 6,271,973, State Prison Population: 24,008, Probation Population: 116,431, Violent Crime Rate: National Ranking: 29th //2009// Source: U.S. Drug Enforcement Administration- www.dea.gov.
/2010/Marijuana is second only to tobacco as the most commonly used drug in Indiana with rates of arrests for marijuana possession and sales far above the national average.//2010//

The Environmental Integrity Project named 12 Indiana coal-burning power plants, including one on the Southside of Indianapolis, among the 50 "dirtiest" in the country for producing health-damaging pollutants. The report underscores the potential health threat from power company smokestacks throughout Indiana. With one exception, the Indiana companies did not challenge the group's findings. The report, "Dirty Kilowatts: America's Most Polluting Power Plants," compiled data from the U.S. Environmental Protection Agency and the Department of Energy's Energy Information Administration for sulfur dioxide, nitrogen oxides, mercury and carbon dioxide. The mercury data were from 2002, and the rest of the information came from 2004. See http://www.environmentalintegrity.org/pub315.cfm /2008/In 2006, Indiana was identified as having 5 of the "dirtiest" coal-burning power plants in the nation -- more than any other state.//2008// Source: http://www.environmentalintegrity.org/pub385.cfm Target = Indiana (5);

According to the Indianapolis Star, April 15, 2005, Marion County's child welfare program faces a $20 million deficit and will likely have to borrow money this year to feed and clothe more than 3,000 children. An increase in the number of children needing care has driven costs up. New children sent into the system by the juvenile court in 2004 had increased to more than 2,000, up from a figure of 540 in 1996. The Office of Family and Children is largely paid for by county taxes but is managed by the state, leaving county elected officials holding the purse strings with no oversight on spending and little incentive to increase funding. Similar structural problems statewide played a role in the development of a separate Department of Child Services at the state level distinct from the rest of state social services.

Planned Parenthood of Indiana sued Attorney General Steve Carter to stop his office from seizing the medical records of 73 low-income Medicaid patients who have sought reproductive services. None of the records involves abortions. The Attorney General's Medicaid Fraud Control Unit was investigating an incident report or complaint alleging failure to report statutory rape. The eight records already turned over are of 12- and 13-year-old patients. In Indiana, anyone under age 14 who is sexually active is considered to be a victim of rape. Planned Parenthood maintains its personnel follow the law and report those patients to child protective services for further review. The Indiana Civil Liberties Union filed the lawsuit on behalf of Planned Parenthood. The record seizure has been postponed by court injunction./2007/A decision is pending in the Indiana Court of Appeals.//2007// /2008/The Attorney General has decided not to appeal the case further, with the result that the records in question will not be turned over to the Attorney General.//2008// Source: http://www.ppin.org/news.aspx?NewsID=44 Target = Sept. 22 decision

Signed by Governor Daniels, new 2005 State Laws:
*Create a new cabinet level Department of Child Services to provide child welfare and protective services. This department takes over these duties from the Family and Social Services Administration (FSSA)
*Require all counties of Indiana to observe Daylight Savings Time beginning 2006. Since 1971, most of Indiana has not observed DST, while the counties nearest Chicago synchronized with Chicago
*Require FSSA Department of Mental Health, Indiana Department of Child Services and Indiana Department of Education to develop a plan for children's emotional and developmental health
*Require FSSA Office of Medicaid Policy and Planning to seek a family planning waiver for Medicaid
*Create a state Department of Homeland Security to take over duties from several state agencies that will be abolished or re-assigned
*Provide health coverage for the surviving spouse and dependent children of active Indiana State Police officers killed in the line of duty
*Increase the penalty for voyeurism from a misdemeanor to a felony if the offender has a previous conviction for voyeurism
*Start a "Code Adam" program to help find missing children in certain state buildings. The system would notify state employees about a missing child in the building, and employees could then stop normal work to help search for the child and monitor exits
*Make it a misdemeanor for someone to intentionally provide dental hygienist services without a license
*Require most voters to show State issued or military ID to cast a valid vote (Indiana's ACLU has filed suit to contest this law on behalf of homeless and low-income residents)
*Create the Office of Inspector General, reporting to the Governor, to investigate fraud and abuse in state government and tighten State ethics rules
*Restrict the sale of cold medicines that contain chemicals that can be used to create methamphetamines
*Raise speed limits on most state highways to 60mph and Interstate highways to 70mph
*Require child care homes that receive a voucher payment and licensed child care homes to receive training concerning safe sleeping practices for children and require the Division of Family and Children to provide or approve training concerning safe sleeping practices for children
*Require ISDH to adopt rules for the case management of children with lead poisoning and allow ISDH to coordinate lead poisoning outreach programs with social service organizations and require OMPP to develop measures to evaluate Medicaid managed care organizations in screening children for lead poisoning, a system to maintain the results and a performance incentive program
*Require ISDH to develop storm safety guidelines to schools and make them available to child care centers, day care centers and public parks and require Department of Education to distribute the guidelines to all public and non-public schools in Indiana.
/2007/New state laws signed by Governor Daniels effective July 1, 2006:
*Require injuries resulting from fireworks or pyrotechnics be reported to ISDH
*Create sexual assault standards and a certification board to certify sexual assault victim

advocates, transfer control of the new sexual assault victim's account from ISDH to the new board, and repeal the sexual assault victim's assistance fund
*Require ISDH to study the use of drugs, alcohol, and tobacco by pregnant women and submit a report to the legislative council and health finance commission by Oct. 1, 2006
*Allow employers to implement financial incentives related to employer provided health benefits to reduce employee tobacco use
*Require each school board to establish a coordinated school health advisory council to develop a local wellness policy that complies with certain federal requirements
*Specify a physician's duty to monitor bariatric surgery patients for 5 years, establish topics that must be discussed prior to surgery, specify the information that must be reported to the ISDH, and require 6 months of supervised nonsurgical treatment before health insurance, state health care plan or health maintenance organization are required to cover surgical treatment
*Establish the ISDH as the lead agency for the development and implementation of a statewide trauma system and adopt rules regarding the system
*Allow the Office of Medicaid Policy and Planning to apply for federal approval to amend the state Medicaid plan to include a pay-in option
*Require certain licensed professionals to provide the professional licensing agency or the ISDH with their Social Security numbers
*Create a water shortage task force to develop and implement an updated water shortage plan and address other surface and ground water issues.//2007//
/2008/New state laws passed by the legislature that the Governor is expected to sign for 2007:
*House Enrolled Act 1001 which provides funding for K-12 education, Medicaid, transportation and other state services. This Act will devote $92 million to help school districts launch full-day kindergarten.
* House Enrolled Act 1678 would raise the state's cigarette tax by 44 cents to help fund health coverage for 132,000 uninsured Hoosiers. It also provides for a tax credit related to small employer qualified wellness programs, increase Medicaid coverage for pregnant women to 200% FPL allows for presumptive eligibility for ambulatory pregnant women and raises eligibility for children to 300% FPL.
*House Enrolled Act 1033 will require all new mobile homes to come equipped with emergency weather radios.
*House Enrolled Act 1548 would require ISDH to coordinate the donation, collection, and storage of umbilical cord blood from newborns
*Senate Enrolled Act 327 requires written notice for the parents of sixth grade girls, informing them about the connection between cervical cancer and the human papillomavirus. Also informs about vaccinations
*House Enrolled Act 1237 will require nearly all motorists in the state to wear seat belts, including those riding in back seats, pickup trucks and SUVs
*Senate Enrolled Act 9 will let local governments restrict or ban the use of fireworks except on New Year's Eve, New Year's Day and an 11 day period around July 4
*House Enrollment Act 1027 will tie Indiana's minimum wage to the federal minimum wage
*House Bill 1116 which requires emergency procedures training for teachers. Teachers will have training in cardiopulmonary resuscitation (CPR), removing obstructions to a person's airway, and the Heimlich maneuver before obtaining an initial license as a teacher
*Senate Bill 0207 Requires the state department of health, in regards to Medical adverse events reporting, to enter into an agreement with an agency to collect, analyze, interpret, and disseminate findings on a statewide basis until June 30, 2010, regarding patient safety
*House Bill 1457 reauthorizes the Indiana Birth Defects and Problem registry for 10 more years and establishes the prenatal substance use commission to develop and recommend a coordinated plan to improve early intervention and treatment for pregnant women who abuse alcohol or drugs or use tobacco. It also requires the first meeting of the commission shall be convened before October 15, 2007.//2008//
/2009/ New state laws signed by Governor Daniels
*HB1113 - Birth certificate fraud. Digest: Increases from a Class A misdemeanor to a Class D felony the penalty for: (1) making a false or fraudulent statement when applying for a birth certificate or when applying for permission to inspect birth records; (2) altering, counterfeiting, or

mutilating a certified copy of a birth certificate; or (3) using an altered, counterfeit, or mutilated copy of a birth certificate.
*HB1171 - Autism training for EMS personnel. Digest: Requires certified emergency medical services (EMS) personnel to successfully complete a course of education and training on autism beginning January 1, 2009. (The introduced version of this bill was prepared by the Indiana commission on autism.)
*HB1172 - Various professions and occupations. Digest: Codifies the uniform emergency volunteer health practitioners act to provide a procedure for recognizing other states' licenses for health practitioners who volunteer to provide assistance during an emergency requiring significant health care assistance. Requires the office of the secretary of family and social services to form a nonprofit corporation to establish and operate an umbilical cord blood bank. Requires the nonprofit corporation to establish an umbilical cord blood donation initiative to promote public awareness concerning the medical benefits of umbilical cord blood. Amends the locations in which a dental hygienist may practice under direct supervision, prescriptive supervision, and without supervision of a dentist. Establishes requirements for a dental hygienist to administer local dental anesthesia. Requires a dental assistant to work under the direct supervision of a dentist. Specifies certain procedures that may and may not be delegated to a dental assistant. Establishes licensing and continuing education requirements for marriage and family therapist associates, and requires emergency rules for the implementation of the licensure. Requires the office of Medicaid policy and planning to receive approval to cover umbilical cord transplants under the Medicaid program. Makes conforming changes. Requires the health finance commission to address domestic violence programs. Repeals a provision that abolishes and transfers the rights, powers, and duties of the state board of examination and registration of nurses.
*HB1266 - Priority for receiving services under Medicaid waivers. Digest: Requires the office of Medicaid policy and planning to apply to the United States Department of Health and Human Services to amend certain waivers to allow specified individuals to be given priority in receiving services under the waiver.
*SB0026 - Smoke detectors in rental properties. Digest: Makes it a Class B infraction if a landlord fails to: (1) properly install a smoke detector at the time a tenant moves in; or (2) repair an inoperative hard wired smoke detector within seven days of receiving notice of the need for repair. Increases the penalty to a Class A infraction for a subsequent offense. Provides that a landlord and a tenant may not waive the requirement that a smoke detector be installed in each rental unit. Requires a tenant to replace batteries as needed in a battery operated smoke detector and to provide written notice of any malfunctions of a hard wired smoke detector to the landlord. Permits a fire department to inspect a private dwelling upon the request of the owner or primary lessee who resides in the dwelling.
*SB0028 - Fire safe cigarettes. Digest: Establishes reduced ignition propensity standards for cigarettes. Authorizes the state fire marshal, the department of state revenue, and the alcohol and tobacco commission to monitor and enforce the standards. Provides for certification fees and penalties. Establishes: (1) the reduced ignition propensity standards for cigarettes fund; and (2) the fire prevention and public safety fund.
*SB0042 - Human services. Digest: Adds the determination of whether a managed care organization that has contracted with the state to provide Medicaid services has performed the terms of the contract to the duties of the select joint commission on Medicaid oversight (commission). Extends the expiration of the office of the secretary of family and social services (office), certain divisions within the office, and the office of Medicaid policy and planning until January 1, 2010, and provides that actions taken after December 31, 2007, by the office, certain divisions within the office, and the office of Medicaid policy and planning are legalized and validated to the same extent that the actions would have been legal and valid if they had been taken before January 1, 2008. Requires certain managed care organizations participating in the Medicaid program to: (1) be accredited by the National Committee for Quality Assurance within certain timeframes; and (2) accept electronic claims for payment.
*SB0143 - Childhood lead poisoning prevention. Digest: Specifies certain requirements for laboratories, the state department of health, local health departments, and retail establishments related to childhood lead poisoning prevention. Provides for certain actions by the state

department of health for noncompliance with certain provisions. Establishes the childhood lead poisoning prevention fund for outreach and prevention activities. Establishes a lead-safe housing advisory council to make recommendations related to lead poisoning prevention. Requires an interim committee to study issues related to childhood lead poisoning prevention. (The introduced version of this bill was prepared by the health finance commission).
*SB0156 - Communicable disease rules. Digest: Specifies that the state department of health may adopt emergency rules concerning communicable diseases. (The introduced version of this bill was prepared by the health finance commission).
*SB0157 - Opioid treatment programs. Digest: Changes the term "methadone treatment" to "opioid treatment" for purposes of the law concerning certification of opiate addiction treatment facilities. Requires approval and certification for each location that an opioid treatment program is operated. Requires an opioid treatment program to: (1) periodically and randomly test a patient for the use of specified drugs; and (2) take certain actions if the drug test is positive for an illegal drug other than the drug being used for the patient's treatment. Requires the division of mental health and addiction to adopt rules on: (1) standards for operation of an opioid treatment program; (2) a requirement that the opioid treatment facilities submit a current diversion control plan; and (3) fees to be paid by an opioid treatment facility. Requires the division to create a central registry and prepare a biennial report. Specifies violations and penalties. Repeals the expiration of current law requiring a methadone diversion control and oversight program.
*SB0164 - Human services matters. Digest: Specifies that eligibility for the children's health insurance program is limited to a child whose family annual income is not more than 300% of the federal income poverty level or the maximum percentage approved by the federal government if the approved percentage is less than 300%. Requires the health finance commission to study during the 2008 interim the feasibility and costs of allowing individuals who meet certain requirements to participate in the Indiana check-up plan without state funding for the coverage.
*SB0249 - Emergency medical services commission. Digest: Requires the emergency medical services commission to adopt rules concerning the triage and transportation protocols for the transportation of trauma patients.
*SB0315 - Aging and long term care services. Digest: Provides that a person who has made certain asset transfers is not eligible for residential care assistance. Requires the adoption of rules to implement: (1) a screening and counseling program for individuals seeking long term care services; (2) a process of prior approval for certain individuals seeking admission to a nursing facility; and (3) the annual review of Medicaid rates. //2009//

Signed by Governor Daniels, new 2009 State Laws:
/2010/* Budget bill : Previously, the CSHCS Program was funded by property tax levies, but that source of funding has been eliminated. The amount of funding through state appropriations, though originally intended to approximate the amount from property tax levies, was set at $13,862,040 for state FY2010.
****SB 98: Mental health Medicaid quality advisory committee. Effective Date: July 1, 2009***
Summary- Establishes the mental health Medicaid quality advisory committee as a permanent committee to advise the drug utilization review board.
****SB 102: Coverage of mental health services in CHIP. Effective Date: July 1, 2009***
Summary- Specifies mental health services that must be covered under the children's health insurance program (CHIP).
****SB 202: Lead-based paint activities. Effective Date: July 1, 2009.***
Summary- The bill provides that lead-based paint activities rules adopted before July 1, 2009, by the Air Pollution Control Board are considered rules of the ISDH after December 31, 2009, and requires the ISDH to adopt rules to replace the rules of the control board.
****SB 219: Immunizations and student vision tests. Effective Date: July 1, 2009***
Summary- Includes a physician's designee and a pharmacist's designee as persons who may provide immunization data to the immunization data registry. Adds: (1) a provider's designee; (2) a child placing agency; and (3) a college or university; as persons to whom ISDH may release information from the immunization data registry. Requires ISDH to establish a panel to study expanding access to the registry.
Requires ISDH to adopt rules to require school age children to receive immunizations

against: (1) meningitis; (2) varicella; and (3) pertussis. Requires a school corporation's governing body and superintendent to receive certain information about vision tests performed in the schools.
****SB 554: Breast cancer screening and Medicaid eligibility. Effective Date: July 1, 2009***
Summary- This bill adds additional providers to those who are authorized in the screening for breast or cervical cancer for individuals in determining the individual's eligibility for participation in Medicaid. The bill requires the Indiana State Department of Health (ISDH) to change the ISDH's Breast and Cervical Cancer Screening Program plan to designate Indiana as an option three state for the program.
****SB 481: Electronic birth and death registration. Effective Date: July 1, 2009 (Implements in 2011)***
Summary- Requires the state department of health to develop and implement on January 1, 2011, electronic birth and death registration systems to be used to record birth and death information. Specifies the time frames for submitting the records. This bill requires ISDH to develop and implement electronic birth and death registration systems to be used in the state to record birth, and death information. The bill will also require county health officers, funeral directors, and physicians to use the electronic death recording system.
****SB 440: Air quality. Effective Date: July 1, 2009***
Summary- This bill requires the Indiana State Department of Health (ISDH) to adopt rules concerning indoor air quality in schools and state agencies. The bill provides that after the ISDH inspects a school or state agency for indoor air quality as the result of a complaint, the ISDH must report certain information. It provides that such a complaint must be in writing and may be made by electronic mail. The bill allows the ISDH to release the name of a complainant only if the complainant has authorized the release in writing. The bill requires the ISDH to post minutes of each meeting of the Air Quality Panel on the ISDH web site not later than 45 days after the meeting.
The bill also requires the ISDH to: (1) distribute a manual of best practices for managing indoor air quality at schools and allows ISDH to use a manual developed by other states and federal health and environmental agencies; and (2) review and revise the manual at least once every three years. The bill further provides that, after June 30, 2009, if the ISDH amends the rules concerning health and safety requirements for school buildings and school sites, the ISDH must consider the effects of outdoor air quality when establishing criteria for school siting.//2010//

Governor Daniels formed a Hoosier Health Care Cabinet, a group of state employees with backgrounds in health care delivery and financing. Cabinet members include Family and Social Services Administration (FSSA) Secretary Mitch Roob, State Health Deputy Commissioner Mary Hill, FSSA CFO Dick Rhoad, FSSA Director of Health Policy for Medicaid Jeanne LaBrecque and FSSA Chief of Staff Anne Murphy. The direction for this group is not yet available./2007/ The Health Cabinet has overseen several projects such as: integration of public health principles into the delivery of quality healthcare to Medicaid recipients; systems evaluation to improve lead screening rates; rebuilding the service delivery model for children with developmental disabilities through coordination of education, public health, and human services resources; statewide leadership on the development of interactive electronic health information capabilities, with emphasis on security and privacy issues, as well as clinical messaging; and Removing regulatory impediments to the development of local traumatic brain injury facilities, as well as respite care facilities for families with disabled children.//2007//***/2010/Currently the new Secretary of the Family and Social Services Administration (FSSA) is Ann W. Murphy, and the new Medicaid Director is Pat Casanova.//2010//***

Gov. Daniels announced a new statewide program to help Hoosiers find and apply for programs providing free or lower cost prescription drugs. The program will expand on a privately run program in southern Indiana. The Evansville program allows people to access low-cost prescription drug programs by inputting basic information into a computer web site. The system searches for the best discount program and provides the application. Concerned that only one in

10 people who are eligible for such programs take advantage of them, the governor hopes "Rx for Indiana" will bolster those numbers. "Rx for Indiana" will offer information on more than 2,400 drugs and more than 300 discount programs, including those run by pharmaceutical companies and the state. The site, www.rxforindiana.org, includes a Spanish-language version and a toll-free number, (877) 793-0765, which has Spanish-speaking operators to help guide the individual through the application process./2007/ Over 98,000 Indiana residents accessed the Rx for Indiana website with 74% initially qualifying for assistance.//2007//
/2010/Updated information for number of "hits" on the Rx for Indiana site will be available & entered in August//2010//

ISDH CURRENT PRIORITIES and INITIATIVES
Indiana State Department of Health (ISDH) is charged with central planning and regulatory development and administration for all health care delivery in Indiana and with improving the overall health of the population through education, advocacy and program support. Indiana's 94 local health departments operate independently from ISDH as arms of local or county government. Many local health departments receive grants from ISDH Maternal and Children's Special Health Care (MCSHC), the division charged with carrying out the goals of Title V of the Social Security Act.

Indiana has a mix of for-profit and not-for-profit hospitals and a broad array of local clinics, many of which are also ISDH MCSHC grantees. Additionally, MCSHC contracts with a number of consulting groups, media services organizations and universities to provide planning, educational and public information programs to advance maternal and child health in the state.

STATE HEALTH PERFORMANCE PLAN
Indiana State Department of Health (ISDH) issued the 2005 State Health Performance Plan (SHPP) that set priorities in two areas: Health Status and Health Systems. Health Status Goals: Chronic Disease (heart disease, cancer, diabetes, asthma, hypertension), Infant mortality and prematurity, Minority health disparities, and Obesity. Health Systems Goals: Access to primary care (particularly for underserved populations), Health care quality (Regulation, Promoting evidenced-based medicine and best practices) and Public health infrastructure (Staffing {number, skills/training, age}, Budgets, Communication and Information Technology).

The following sections from the SHPP outline priorities for which MCSHC is partly or primarily responsible.

The SHPP identifies baseline chronic disease levels in Indiana and sets goals for 2010 in relation to the Healthy People 2010 goals. These goals include both total disease indicators and weighted indicators for Black and Hispanic populations. SHPP notes a 2002 baseline of 1.3 asthma-related deaths per 100,000 among children age 0-14 and a goal of 1/100,000 by 2010. For Black children, the 2000 baseline is 6.3 deaths per 100,000 with a 2010 goal of 3.8/100,000. ISDH Priority Goal: Reduce asthma morbidity and mortality rates in Indiana.

SHPP shows a 2002 baseline of 7.6 infant deaths in 1,000 (6.5 white, 15.6 black), 9.4% prematurity (9% white, 12.5% black) and 7.6% low birth weight (6.9% white, 12.9% black). ISDH Priority Goal: Decrease Indiana's infant mortality and prematurity rates.
/2008/ 2003 infant mortality rate was 7.3 per 1,000 (6.5% white, 14.2% black) //2008// ***/2010/ Infant mortality has been gradually, very slowly increasing over time in Indiana so that in 2006 it was 7.9 per 1,000. 2007 data should be available in August and this figure will be updated then including breakdown of black and white infant mortality.//2010//***

Obesity in Indiana is epidemic. SHPP notes 61.3% of adults are overweight and 26% obese (2003). Among high school students, those rates are 25.7% and 14.2%. ISDH Priority Goal: Decrease the percentage of overweight and obese persons in Indiana.***/2010/To help address the critical health and financial issue of obesity, Indiana has partnered with Virgin***

HealthMiles in a year-long campaign to help raise awareness about Indiana's obesity epidemic. Virgin HealthMiles, part of Sir Richard Branson's Virgin Group, has very generously offered ISDH the opportunity to earn up to $125,000 in donations for our state's obesity prevention programs.//2010//

/2007/ In July of 2005, Governor Daniels initiated INShape Indiana, a statewide web-based health initiative. INShape Indiana is designed to help Hoosiers make healthy lifestyle choices. The INShape Indiana website includes a clearinghouse of information on programs, activities, and events from all over the state related to nutrition, physical activity, and tobacco cessation, a bi-weekly tracking mechanism that allows individuals to monitor their progress towards a healthier lifestyle, and the opportunity to celebrate individual and group success stories and serve as healthy role models for other Hoosiers. INShape Indiana promotes personal responsibility for health behaviors while promoting good nutrition, smoking cessation and increased physical activity. All MCSHC grantees are required to incorporate activities and information about INShape Indiana into their project activities.//2007///***2010/According to the March 12th, 2009 Indianapolis Star, Indiana ranks near the bottom in a new nationwide survey of well-being that queries people on mental, physical and economic health. The massive survey of Americans' daily lives -- from how they are treated on the job to whether they had access to fresh fruits and vegetables -- is designed to create a sort of Dow Jones industrial average for policymakers dealing with health care. Indiana ranked 45th among the 50 states for overall well-being in the Gallup-Healthways survey. The survey broke findings down by congressional district. Indiana's 2nd District, home to South Bend, ranked 423rd out of the 435 districts nationwide for overall well-being. It ranked last for healthy behavior. OUR BEST RANKING: 29th for access to basic necessities. OUR WORST RANKING:48th for healthy behavior. OUR OTHER RANKINGS: 35th for physical health. 42nd for "life evaluation." 43rd for emotional health. 45th for work quality. Of note about other congressional districts: District 1: Work quality ranked 427th out of 435. District 5: Basic access to necessities ranked 57th out of 435. District 7: Healthy behavior ranked 411th out of 435.//2010//***Source: Gallup -Healthways Well-Being Index- March 12, 2009 Indianapolis Star Newspaper

Agency Priority Goals are to: Increase the number of minorities entering the field of public health; develop a more culturally competent workforce; enhance access to primary care; promote and improve the quality of health care provided by Indiana health care providers; and improve Indiana's public health care infrastructure./2007/New ISDH agency priority goals which all grantees must include are: Data driven efforts for both health conditions and health systems initiatives that are effective, efficient, provide timely data collection, and ensure evidence based results; Promote INShape Indiana -- this includes agency wide participation and engagement of all components of communities and collaborative partners; Integration of medical care with public health: Preparedness -- Planning and training for poised and effective response to threats that cannot be prevented.//2007///2009/In 2007, the Indiana State Department of Health initiated a Public Health System Quality Improvement Project. The overarching goal of this program is to educate the public health workforce on the 10 Essential Public Health Services, and to begin preparing public health agencies for voluntary national accreditation, which is scheduled to be available beginning in 2011. This accreditation will be largely based on the 10 Essential Services. A State Accreditation Task Force has been established and other individual work teams have also been formed to address various issues that were identified in assessments that took place in 2007.//2009///***2010/ISDH conducted an internal agency assessment on the Ten Essential Public Health Services. A cross section of programs, including several MCH programs, completed a series of surveys, one for each Service. Results were compiled for each Service and reviewed by a team of external partners and program staff, who then formulated a list of recommendations. In 2009, ISDH is continuing to build capacity for Essential Service delivery through 2 initiatives: quality/performance improvement & accreditation preparation.//2010//***

TITLE V PRIORITY SELECTION

The MCSHC statewide needs assessment is the first step in determining priorities, identifying emerging issues and planning the development and delivery of Title V services.

ISDH MCSHC contracted with an epidemiologist to pull together information from 10 regional epidemiologists in the State's Public Health Preparedness program, along with other statistical information and data generated by other consultant contractors to create the 2006-2010 MCSHC Needs Assessment. Below is an overview of those findings not previously detailed in the SHPP above.

Rates of overweight and obesity increased in Indiana from 1999 to 2002, mirroring national trends. Currently, more than 60% of Indiana's population is overweight, with more than 25% obese. These rates are slightly higher than national averages.

Only 42.8% of Indiana women were normal weight before pregnancy in 2001. According to the CDC Pregnancy Nutrition Surveillance System of pregnant women participating in WIC, 13.4% were overweight, 29.2% were very overweight, 9.7% were underweight and 4.9% were very underweight.

Pregnancy rates among Indiana women age 20 and less decreased from 3.2% in 1999 to 2.6% in 2002. Black teenagers are 2.5 times more likely to become pregnant than white teenagers. /2008/ The percent of births to women less than age 20 was 11% in 2003.//2008//

Between 1999 and 2001, the number of induced pregnancy terminations in Indiana decreased by 1.94% to a total number of 11,281 pregnancy terminations in 2001.
/2008/ There were 10,036 induced pregnancy terminations in Indiana in 2004.//2008//

Indiana's 2002 birth rate was 1.38%, below the national average of 1.39%./2007/Indiana's 2003 birth rate was 1.40%, below the national average of 1.41%//2007//

In 2002, there were 40 infant deaths due to SIDS in Indiana resulting in a SIDS age specific death rate of 47 per 100,000 live births. The Healthy People 2010 goal is to reduce the SIDS mortality rate to 30 per 100,000 live births. In whites SIDS is the third leading cause of death with age specific death rate of 45.3 per 100,000 live births (n=33) where as in blacks SIDS deaths ranked 5th (n=14) after short gestation/low birth weight disorders, congenital defects, accidents, and maternal pregnancy complications./2008/In 2004, there were 42 infant deaths due to SIDS, resulting in a rate of .48 per 1000 live births. Of the 42 infants, 32 were white infants and 8 were black infants.//2008///2009/Trend analysis in yearly infant mortality rates due to SIDS in Indiana between 1990 and 2006 reveals a consistent decline between 1993 and 2002 whereas mortality rates due to combined SIDS, other SUIDs, and unknown cause ceased to decline past 1998. It was concluded that the more recent decline in SIDS rate and increase in Accidental Suffocation and Strangulation in Bed (ASSB) rates (after 1998) were likely not a true decline in SIDS or increase in ASSB, but due to changes in the ways these infant deaths were being reported and classified. Percent distribution of infant deaths due to sudden infant death syndrome (SIDS), other sudden unexpected infant deaths (SUIDs), and unknown cause in selected counties during 1999-2006 shows that Allen County had the highest infant mortality rate due to SIDS (104.4) compared to Marion County with the lowest infant mortality rate due to SIDS deaths (38.5). Indiana, Washington State, and Washington D.C. were chosen to be a part of the collaboration with the Gates Foundations and First Candle to provide baby cribs to at risk families to decrease Postneonatal deaths due to unsafe sleeping arrangements. This five year program will include provider and consumer education, distribution of cribs to at risk families through county coalitions, and an evaluation component on the efficacy of the program in reducing SUIDS due to unsafe sleep environments. //2009//***/2010/The First Candle executive committee has reviewed educational materials and the cribs that will be used. A plan is being considered for distribution of the cribs.//2010//***

At 19.1% in 2002, Indiana had the 6th highest maternal smoking rate among 49 reporting states. This rate is higher among whites than blacks. While Indiana has seen a steady decrease in this rate, it is unlikely the state will reach the HP2010 goal of no more than 1%./2007/In 2003 the maternal smoking rate decreased to 18.5%.//2007//***/2010/In 2006, the maternal smoking rate in Indiana decreased to 17.3%. The white maternal smoking rate was the highest at 18.1%.//2010//***

However, results from the 2004 Indiana Youth Tobacco Survey show that the percentage of children who smoked in grades 6 through 8 dropped to 7.8% from 9.8% in 2000. In grades 9 through 12, the percentage of smokers dropped to 21% from 32% in 2000. Nationally, 22.3% of high school students and 8.1% of middle school students said they had smoked cigarettes last year, according to CDC.***/2010/According to the 2007 Indiana YRBS, 53.3% of high school students reported lifetime cigarette use and 22.5% reported current cigarette use. Percentages for both lifetime and current cigarette use among high school students in Indiana are greater than the national average.//2010//***

Indiana's infant mortality rate of 0.76% (7.6/1000 live births) in 2002 was higher than the national average of 7/1000. Of the total 649 infant deaths in Indiana in 2002, 68% occurred during the first 28 days of life. The remaining 32% were between 28 and 365 days. White infant mortality was 6.5 while black infant mortality was 15.6 (2.4 times the rate for white infants)./2007/In 2003 the infant mortality rate was 7.3/1000 live births, higher than the national average of 6.85. White infant mortality remained at 6.5, while black infant mortality decreased to 14.2.//2007//***/2010/In 2006 the infant mortality rate was 7.9 per 1000 births. The black infant mortality rate increased to 18.1 per 1000 while white infant mortality decreased to 6.4 per 1000.//2010//***

Racial and income-based disparities exist in nearly all health statistics with low-income women and women with less than high school diploma or GED experiencing higher rates of asthma, obesity, diabetes and heart disease and experiencing these problems at earlier ages. Despite concerted efforts, the black infant mortality rate remained about 2.5 times higher than the white in Indiana. The vast majority - 89% of Indiana's population is white. However, minority populations are growing faster than the white population with the highest growth rate (62%) among Asians

According to the 2003 US National Immunization Survey, Indiana has remained above the national average for percentage of children vaccinated for most individual antigens and all vaccination series. ***/2010/ We still exceed the national average, being at 89.1% in 2007.//2010//***

In 2002, 15.7% of Indiana households had at least one child with asthma. According to the Office of Medicaid Policy and Planning (OMPP), of 23,161 children, age 0-17, enrolled in Medicaid in 2003, 10% had an emergency room visit with principal diagnosis of asthma and 4% were hospitalized for asthma. Asthma is the most common diagnosis among children enrolled in CSHCS.***/2010/In 2007 8% of children in Indiana had asthma. Black children had the highest percentage at 15.2%.//2010//***

Between 1999 and 2003, Allen, Clinton, Elkhart, Lake, Marion, St Joseph and Wayne Counties had the highest number of children with elevated blood lead levels. Except Elkhart, these counties have percentages of children living below poverty well above the state average of 14.4%. In 2003, the Childhood Lead Poisoning Program indicated that 2.9% of 31,413 children screened had elevated blood levels./2007/Currently only Marion County requires the testing of a home where a child has been lead poisoned. No county in Indiana requires testing of housing units built before 1950 prior to being rented.//2007// ***/2010/ By 2007 ISDH LEAD Program had succeeded in lowering the percentage of children screened with elevated blood lead levels to 0.8%, an excellent success story.//2010//***

Indiana Attorney General, Stephen Carter, has provided a letter of support to all local health

departments and cities applying for lead poisoning prevention and abatement grants indicating an aggressive stance to require landlords to reduce lead paint hazards and pursuing legal expenses in cases requiring court action.

Use of protective dental sealants among Indiana children increased by 13.5% from 1999-2003. Further data indicates sealants are increasing among all races. At 47.2% in 2002, Indiana was very close to the HP 2010 goal of 50% of children receiving protective dental sealants./2007/ 46% of third grade children had at least one permanent molar tooth treated with a protective sealant in 2005.//2007//

The leading causes in Indiana's 2002 adolescent death rate of 83.2/100,000 were unintentional injury 43.9%, homicide 14.5% and suicide, 13%. Homicide was the leading cause of death for black adolescents in Indiana, accounting for more of the 147.65/100,000 death rate than all other causes combined.
/2008/ In 2004, Homicide claimed 91 Indiana citizens ages 15-24; of those, 59 were black individuals and 32 were white. Suicide claimed another 89, with blacks accounting for 8 deaths and whites for 77.//2008///***2010/The overall adolescent death rate (15-24 year olds) was 82.6 in 2006. The top three causes of death were unintentional injury (47.9%, 353/737), homicide (14.5%, 107/737) and suicide (12.3%, 91/737). Homicide was the leading cause of death for black adolescents in Indiana, accounting for more of the 141.7/100,000 death rate than all other causes combined. In 2006, homicide claimed 107 Indiana citizens ages 15-24; of those 72 were black individuals and 35 were white. Suicide claimed 91 lives; of those, 86 were white and 3 were black.//2010//***

From 1999 - 2003, reported cases of child abuse fluctuate between 3,620 and 4,415. Neglect cases rose to 15,634 in 2000 and tapered to 12,308 in 2003. However, a number of high profile cases during the election of 2004 have placed attention on this issue. Governor Daniels campaigned with a promise to separate child protective services from FSSA./2007/In 2004 there were 24,995 reports of abuse and/or neglect with 57 substantiated fatalities. The Department of Child Services (DCS) was established in January 2005 by an executive order of the Governor to better care for children by providing more direct attention and oversight in two critical areas: protection of children and child support enforcement. The DCS protects children and strengthens families through services that focus on family support and preservation. The department administers child support, child protection, adoption and foster care throughout the state of Indiana.//2007//

Self-reported monthly alcohol use among high school seniors has dropped from 51.7% to 46.1% from 1999-2003, mirroring national averages. Marijuana and psychedelic consumption has also dropped. Cocaine use remained at 2.5% among Indiana adolescents in 2003, above the national average. Inhalant use also increased among younger adolescents./2007/The 2005 Youth Risk Behavior Surveillance System showed an increase from 12.9% in 2003 to 14.1% in 2005 for inhalant use. Teen age alcohol consumption within the past 30 days decreased to 41.4% in 2005 from 44.9% in 2003.//2007///***2010/According to the 2007 Indiana YRBS, cocaine, methamphetamine and inhalant use by Hoosier high schools students are greater than the national average. A comparison between 2005 YRBS and 2007 YRBS data reveal that lifetime use of cocaine, injectable drugs, inhalants and heroin use increased from 2005 to 2007. Additionally, the 2007 Indiana YRBS reveals that there were increases in the lifetime and current use of alcohol among high school students compared to 2005 data. The percentage of students who engage in binge drinking has increased from 24.6% in 2005 to 28.2% in 2007.//2010//***

DEVELOPMENT OF PRIORITIES
ISDH MCSHC determines priorities based on the following considerations: health and capacity data; priority survey data; state health plan; MCH objectives; & what other organizations are doing statewide. Priorities must meet the following criteria: ISDH must be able to address the problem; solutions must be feasible; resources must be available; and the problem must fit with

purposes of Title V, Healthy People 2010, and the Governor's priorities. ISDH MCSHC addresses priorities through commitment of funding, staff time and working to focus the efforts of ISDH and other agencies on those priorities. MCSHC continuously evaluates programs and monitors emerging issues through staff effort and contracts with consultants to conduct needs assessment, project evaluation, public hearings, focus groups, surveys and analysis. /2007/MCSHC has developed a Priority Health Need for the MCH population for 2006-2011 to increase the rate of maternal smoking cessation and reduce the rates of domestic violence to women and children, child abuse and injury in Indiana. In 2003, domestic violence, caregiving stress and poverty were the top 3 challenges Central Indiana women faced. MCHSC will contract with the Indiana Coalition Against Domestic Violence to conduct a series of workshops entitled "Improving the Healthcare Response to Domestic Violence in Indiana". During 2003 Indiana ranked first nationally in unintentional suffocation deaths of infants less than 1 year of age.//2007//

B. Agency Capacity

B. Agency Capacity

In the State of Indiana, the Title V program is administered through the Maternal & Children's Special Health Care Services division (MCSHC) of the Indiana State Department of Health (ISDH) Human Health Services Commission. MCSHC manages a number of funds from federal and state sources including Title V for an estimated total allocation of $35,832,070 for FY 2005. Additionally, most MCSHC grantees leverage local resources to provide a required 30% match to grant funds. MCSHC extends the capacity by outsourcing services to local entities.

MCSHC provides funding for projects in all levels of the MCH Pyramid. MCSHC staff is directly involved in infrastructure building within ISDH, among other state agencies, and among non-state agencies. Through the Title V Block Grant Federal/State Partnership, MCSHC funds agencies to provide direct medical services for women of childbearing age, pregnant women, infants, and children and acts as payer of last resort for primary and specialty care for children with special health care needs (CSHCN). These grantees/contractors also provide enabling services (such as care coordination) to prenatal clients and to families of CSHCN. MCSHC also creates and implements population-based education on topics like adolescent pregnancy prevention. See Narrative Part C for a detailed list.

MCSHC staff interface with state physician and dental organizations, Office of Medicaid Policy and Planning (OMPP) and other managed care insurers (especially those working with low-income populations), laboratories that run the newborn screens and meconium screens, not-for-profit groups that are working toward the same improved health outcomes as ISDH MCSHC and other state agencies to coordinate and assure that quality health care is available. MCSHC also monitors statistics for Indiana's Health Status Indicators (HSI) and health outcomes and shares this information with the public.

ISDH is the statutory authority for Maternal and Child Health (Title V) programs, receiving state funds to match Title V funding. By statute, ISDH also operates through MCSHC the following state programs: Children's Special Health Care Services (CSHCS), Newborn Screening and Follow-up, which includes Sickle Cell Education, Screening for Drug Afflicted Babies, Adolescent Pregnancy Prevention, follow-up and education, Universal Newborn Hearing Screening, and the Indiana Birth Defects and Problems Registry.

MCSHC provides information, referral and assistance to Indiana citizens statewide through the Indiana Family Helpline (IFHL). The IFHL helps families and individuals access social and health services for mothers, children and families through telephone and e-mail contact. The IFHL has bilingual employees, uses the ATT Language Line, as well as a TTY line to better serve the hearing impaired. The IFHL is obtaining Alliance of Information & Referral Services accreditation to qualify to become a 211 Information and Referral (I&R) call center for some Indiana counties.

Genomics / Newborn Screening Program goals include increasing public and professional awareness of genetics, assuring access to services, enhancing genetic data collection statewide and improving the quality of the birth defects surveillance system. MCSHC funded projects offer genetic testing, evaluation and counseling, and prenatal diagnosis through support of five regional genetics projects that sponsor clinics in thirteen sites. The Genomics Program Director offers consultation to these and nine (seven non-funded and two state funded) additional Genetics Centers/Programs in Indiana. Genomics also facilitates the Folic Acid Initiative, sponsored by Title V and WIC, a population-based education effort and "Genetics and Your Practice," sponsored by MCSHC and March of Dimes, a professional training opportunity. /2009/Beside the five state funded Genetic Centers, there are now ten additional Genetic Centers/Programs in Indiana that do not receive state funding. The Folic Acid Initiative Campaign concluded in 2007 after the Genetics Implementation Grant was completed, but members of the Fetal Alcohol Spectrum Disorder Task force constructed a new educational module entitled "Working to Prevent FASDs Through High School and Middle School Curricula". The "Genetics and Your Practice," training opportunity is no longer sponsored by the Genomics program. On October 1, 2007 Cystic Fibrosis (CF) was included in the state newborn screen. With the addition of CF, Indiana became 15th state to screen for all 29 target newborn screening conditions recommended by the March of Dimes. Every newborn in Indiana will now be screeded for a total of 45 conditions plus hearing screening.//2009// ***/2010/The Genomics and Newborn Screening webpages were re-designed to be more user-friendly; new webpage content includes family-appropriate fact sheets, information for healthcare providers, and contact information for genetics services providers in Indiana. //2010//***

MCSHC capacity to expand data integration and ISDH program integration was enhanced with receipt of the Genetics Implementation Grant (GIG) in September 2002. Through this grant, the MCSHC Genomics program assists with newborn screening, birth defect and other chronic disease data integration, as well as establishment of medical home, folic acid and genetics education for professionals and consumers. The scope of MCSHC Genomics includes adult chronic diseases and general genetics education and bridges the perinatal and child health services. The Genomics program strives to increase the awareness and understanding of genetic conditions and ensure that all of the approximate 5,000 infants born in Indiana each year with birth defects or genetic conditions have access to genetic services./2007/GIG funding has concluded, but most of the programs initiated with GIG funds have been continued with other resources under the MCSHC Genomics and Newborn Screening Program. A one year extension at no additional cost has been requested to continue Medical Home training and to complete the Indiana Birth Defects and Problems Registry (IBDPR).//2007// /2009/ The GIG grant has been completed for two years. IBDPR is supported through a dedicated birth certificate fee & medical home training is now a focus of the MCSHC Integrated Service Manager.//2009//

Genomics collaborates and coordinates with regional genetic centers (both state sponsored and private providers of genetic services), as well as local agencies, individual providers, hospitals, health departments, the Indiana Perinatal Network (IPN), and the Indiana Chapter of the March of Dimes and builds public health genetics capacity within ISDH. Genomics also houses the Indiana Birth Defects and Problems Registry (IBDPR).

1. Pregnant Women, Mothers and Infants
MCSHC provides the Free Pregnancy Test program, a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The goals of the program include: (1) helping pregnant women obtain early prenatal care, Hoosier Healthwise, and WIC; (2) encouraging women to obtain a high school diploma or GED; (3) decreasing infant mortality and morbidity and the incidence of low birthweight; (4) assisting local communities and grantees to assess for service gaps for planning of future programs; and (5) assisting non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Through this program,

MCSHC has developed an infrastructure of agencies that focus on women of childbearing women age and has created an ongoing database for assessment and evaluation of services offered and needed by sexually active, low-income women. Currently, the Free Pregnancy Test program is available in 63 counties. ***/2010/The Title V Free pregnancy Test program (FPT) is currently available in agencies in 58 counties. Agencies that participate must submit demographic data to MCSHC in exchange for receiving the free tests and they may not charge the client. This program is currently under evaluation to determine success and cost effectiveness.//2010//***

MCSHC provides preventive, primary care, and enabling services for pregnant women, mothers and infants including prenatal health care services through grants to 13 agencies to promote direct prenatal medical services, as well as funding 23 prenatal care coordination projects. The primary objective of these grants is to decrease infant mortality and low birthweight by providing quality, comprehensive, holistic health care to low-income pregnant women in community settings. MCSHC funded prenatal care coordination programs to develop and coordinate access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients. The direct medical and enabling services target pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCSHC staff also trains and certifies community health workers to assist prenatal care coordinators. MCSHC collects, analyzes and disseminates perinatal outcomes to communities to ensure that the planning and delivery of perinatal heath care services meet the needs of the population.

MCSHC develops and enhances capacity to promote and protect the health of all mothers, children and families through Thirteen family care coordination projects that provide enabling services to facilitate a seamless delivery of services for mother and children through outreach, assessment, care planning, advocacy, referral, education and counseling on health behavior risk reduction during both clinic and home visits with the family. Goals are to improve utilization of EPSDT services, immunization service, and primary care providers, and to empower families with education and support to access health, education, and social services they need.

MCSHC provides Family Planning and Women's Health Services through 11 local grantee agencies. The Indiana Family Health Council (Indiana's Title X agency) is contracted to provide clinic monitoring and standards of care for these grantees./2007/Begining in 2007, if approved, MCHSC will provide all Title V Family Planning through IFHC, blending Title V and Title X Family Planning programs.//2007///2009/ All Title X and Title V Family Planning funds are provided through a contract with the Indiana Family Health Council (IFHC).//2009//

The Prenatal Substance Use Prevention Program (PSUPP) is funded through a grant from FSSA Division of Mental Health and Addiction (DMHA) and supplemented with Title V Federal -- State Block Grant Partnership and funds from Indiana Tobacco Prevention and Cessation (ITPC). PSUPP works to prevent birth defects, low birthweight, premature births, and other problems associated with prenatal substance use. There are three primary objectives: (1) identify high risk, chemically dependent pregnant women, provide perinatal addiction prevention education, promote abstinence, provide referrals for treatment, and follow-up; (2) facilitate training and education for professionals and paraprofessionals who do not provide substance abuse treatment, but do work with women of childbearing age, on how to identify high risk, chemically dependent women; and (3) provide public education on the possible hazards to a fetus when alcohol, tobacco, and other drugs are used during pregnancy. Free posters, brochures, and other materials are available upon request through the Indiana Family Helpline. MCSHC supports enabling services for drug use cessation through 15 grantees. In addition, the PSUPP Director builds professional capacity through professional training. This program also interfaces with smoking cessation efforts with prenatal services and ISDH by providing public education./2009/MCSHC continues to support enabling services for alcohol, tobacco and drug (ATOD) use cessation. In addition, the PSUPP Director builds professional capacity through

professional training. This program interfaces with smoking cessation efforts with prenatal services and ISDH by providing public education. During FY2008 MCSHCS screened 4,540 women. //2009// ***/2010/MCSHC continues to support counseling and referral services for alcohol, tobacco, and other drug (ATOD) use cessation. During FY2009, MCSHCS screened 4,850 women.//2010//***

MCSHC Newborn Screening facilitates newborn screening and follow-up programs including metabolic screening, sickle cell follow-up, hearing screening programs, and meconium screening to test for drug-afflicted babies. Newborn screening is performed on every infant born in Indiana. The program is funded by a $62.50 fee for each infant screened collected from each birthing facility by the central testing lab under contract with ISDH MCSHC. The contractor remits $30.00 of each fee to ISDH and retains the balance to pay for laboratory and collection services. Indiana University Medical Center Newborn Screening Laboratory (IU NBS Lab) is the laboratory designated by the Indiana State Department (ISDH) for processing specimens. /2009/In October 2007, Cystic Fibrosis (CF) was added to the list of disorders that Indiana screens for in the newborn screen. An ISDH CF follow-up program, headed by a professional program director, was developed to ensure that all children that screen positive for CF receive the appropriate follow-up care. The addition of CF to the NBS, led to an increase in lab costs. The central testing lab now collects $82.50 for each infant screened. According to the new contract with the lab, which goes into place July 1, 2008, the fee will increase to $85.00 for each infant screened. ISDH will still receive $30.00 for each infant screened. //2009//

A blood test (by heel-stick) is done on all infants shortly after birth to test for 39 metabolic or genetic disorders. Follow-up is done to obtain repeat screens on all abnormal and unsatisfactory screens. If further follow-up is needed, the Newborn Screening Section requests assistance from the local Public Health Nurse. Infants that have a positive screen for one of the designated genetic disorders are referred to the Metabolic Specialist or the Endocrinologist at the Indiana University Medical Center. The ISDH NBS Section works collaboratively with IU NBS Lab, Sickle Cell Program, and the Genomics Program to ensure follow-up and treatment for all infants diagnosed with one of the designated disorders./2009/ The blood test performed shortly after birth now screens for 45 metabolic and/or genetic disorders. //2009//

The MCSHC Early Hearing Detection and Intervention (EHDI) program screens all infants born in Indiana for possible hearing impairments. Those found with hearing impairments receive early intervention and follow-up services. UNHS coordinates with Indiana First Steps Early Intervention Services, hospitals, providers, and other agencies to provide statewide implementation. The goals for infants that do not pass the hearing screening are to receive audiology evaluations by three months of age and to be enrolled in an appropriate intervention program by six months of age. MCSHC EHDI collects comprehensive monthly data via Monthly Summary Reports (MSR) from each of the 108 birthing facilities throughout the state of Indiana and is developing a web-based electronic reporting system to enhance hospitals, audiologists and early intervention coordinators in ensuring timely and accurate evaluation and follow up treatment. The program educates the public, including parents and primary care physicians of the importance of early detection and intervention and works in conjunction with the Indiana School for the Deaf to promote awareness and parent participation in the program./2009/ There are now 102 birthing facilities throughout the state of Indiana.//2009//

MCSHC funds programs for Sickle Cell and Other Hemoglobinopathies. This program provides penicillin, education, care coordination, and counseling for sickle cell clients in the state. There are four regional sites for the care coordination. The Indiana Hemophilia and Thrombosis Center, Inc. (IHTC) also provides sickle cell education to families statewide. This program provides education and consultation to primary and hospital emergency room providers about current therapy for sickle cell disease complications and educational materials to health care providers and patients' families. MCSHC supports the Parents Empowering Parents (PEP) program to assist families living with children with Sickle Cell Disease with parenting./2007/There are 5

regional sites for the care coordination.//2007//

MCSHC also contracts with IHTC to provide outreach to Amish persons with bleeding disorders. The program provides home visiting, health care services, an annual health clinic and factor concentrate to those affected.

Indiana Birth Defects and Problems Registry (IBDPR) is a population-based surveillance system that seeks to promote fetal, infant, and child health, in order to prevent birth defects and childhood developmental disabilities, and to enhance the quality of life of affected Indiana residents. IBDPR collects data on all children in Indiana from birth to age three with congenital anomalies or disabling conditions and up to age five for children with fetal alcohol syndrome and autism. The information provided by the registry has the potential to uncover the environmental causes of defects, thus preventing future cases./2007/IBDPR sent 2003 data to Birth Defects Research, Part A, Clinical and Molecular Teratology, 2006 Congenital Malformation Surveillance Report, showing increased IBDPR capability. IBDPR is a separate program under the Genomics and Newborn Screening Program.//2007///2009/IBDPR continues to submit data annually to the Birth Defects Research Report.//2009//

The data collected for IBDPR is used to (1) detect trends in birth defects and suggest areas for further study, (2) address community concerns about the environmental effects on birth outcomes, (3) evaluate education, screening, and prevention programs and (4) establish efficient referral systems that provide special services for the children with identified birth defects and their families.

Indiana State Law requires a screening test for possible drug affliction in certain newborns. Hospitals and physicians are required to submit a meconium specimen for every infant who meets the selection criteria to test for Amphetamines, Cannabinoids, Cocaine and Opiates. MCSHC contracts with a central lab to provide this screening for the state. MCSHC keeps the data from this program but does not do tracking. Local hospitals and the physicians are responsible to refer the mothers and infants for appropriate treatment, social services and early intervention./2007/Due to newly enacted legislation, MCSHC is conducting a study of the impact of alcohol, drugs, and tobacco use among pregnant women, and available services and making recommendations for improved services. The report will have input from other partners and is due to legislators by October 1, 2006.//2007// /2009/ The October 2006 report resulted in the formation of the Alcohol, Tobacco, and Other Drug (ATOD) Use During Pregnancy task force. This task force is currently in the process of developing a needs assessment.//2009///***2010/Effective January 1, 2009, the Indiana State Department of Health (ISDH) discontinued the Test for Drug Afflicted Babies Program due to financial constraints. //2010//***

2. Children
MCSHC provides preventive and primary care for children through 15 grants to agencies that provide direct medical services and enabling services to children and 6 adolescent health care programs. Many of these grantees are community health centers or are a part of a larger health care facility. They provide direct health care services and health and safety education. Using AAP guidelines and Bright Futures, MCSHC has developed Standards of Care for children 0-21 years of age.

MCSHC administers the Indiana Child Care Health Consultant Program (ICCHCP) through funding provided by FSSA from the Child Care Development Block Grant. MCSHC contracts with an outside entity to provide health education and technical assistance to licensed and unlicensed child care providers serving children 0-8 years of age. ICCHCP is contracted to hire and/or subcontract, educate and supervise qualified community based child care health consultants, identify out-of-home child care providers and develop an infrastructure linking them with child care health consultants in their local community and to identify, recruit, educate, certify, and provide oversight to professional child care health consultants and health advocates. ICCHCP

collaborates with other health and safety providers in the state and with injury prevention efforts within ISDH./2008/In October 2007 the FSS Bureau of Child Care will integrate the Child Care Health Consultant Program into it's Quality Rating System. A Chief Nurse Consultant from MCSHC will continue to act as liaison with ISDH programs//2008//
/2009/ Paths to Quality is promoting high quality child care by providing training and resources to promote children's health and wellness in Indiana Child Care Centers. These educational services are provided statewide by five health professionals on topics such as immunization, communicable disease, sanitation, nutrition, physical activity, and medication administration.//2009//

MCSHC is developing Early Childhood Comprehensive Services (ECCS) through a grant from MCHB to plan a coordinated, comprehensive, community-based system of services for young children from birth through age five and their families. ECCS is a collaborative process across public and private organizations. Core Partners include ISDH, FSSA, Indiana Department of Education (IDOE), Indiana Department of Corrections (IDOC), Indiana Department of Environmental Management (IDEM), the About Special Kids (ASK) program, formally known as Indiana Parent Information Network (IPIN), Indiana Association for the Education of Young Children, Indiana Head Start Association, and Riley Hospital for Children/Child Development Center. Additionally, five Subcommittees were formed and met to address the project's five focus areas which include: access to health insurance and a primary medical provider; mental health and socio-emotional development; early care and education; parent education; and family support. An application for implementation funding with a strategic plan has been submitted to MCHB./2007/The ECCS program is now known as Sunny Start: Healthy Bodies, Healthy Minds.//2007// /2008/ Social and emotional development in young children continues to be a focus of Sunny Start. After receiving final approval from the Sunny Start Core Partners, the Social and Emotional Consensus Statement described above was finalized. Currently, Sunny Start committee members are developing a tool to be used in conjunction with the Consensus Statement that will help individuals assess the social and emotional competencies that their training addresses. Finally, Sunny Start is sponsoring a comprehensive one week Summer Institute in July, 2007 which will help mental health professionals in Indiana build skills in the area of social and emotional development in young children, infants and toddlers. //2008///2009/ Work on Sunny Start this year included marketing the expansion of the Early Childhood Meeting Place(ECMP) website to pediatricians, family practice physicians, and their patients.//2009//
/2010/ This year, the Sunny Start initiative published online and hard copies of a developmental calendar (in English and Spanish) to assist families in understanding the needs of their children from birth to age five, sponsored an Infant Mental Health Summer Training Institute, developed a medical passport for children, sponsored the creation of a 12 hour online course in infant and toddler mental health along with a statewide mentorship opportunity to further training and collaboration, funded a white paper on the state of Infant and Toddler Mental Health in Indiana, published a series of financial fact sheets by and for families, joined a collaborative effort to apply for and share funding of Zero to Three training for early childhood providers to decrease child abuse, and sponsored a physician event in conjunction with the IN Chapter of the AAP to promote Developmental Screening in the Medical Home.//2010//

The Oral Health Director (OHD) which is now located in MCSHC Division and funded by Title V, focuses on education and prevention with a special emphasis on fluoridation. Oral Health staff provide technical assistance and surveillance to communities and schools with fluoridated water supplies. MCSHC supports the Oral Health community-based pit and fissure sealant program. This program's objectives include (1) promoting the use of sealants throughout Indiana and working toward the national health objective to have 50% of children with sealants by Year 2010, and (2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in community dental health programs. MCSHC continues to provide partial funding for the Indiana SEAL program, providing a mobile unit to bring these services to children across the state./2009/ In May 2007, the Oral Health Program was relocated under the MCSHC Title V umbrella. The

new Dental Director, M. Kent Smith DDS, RPh, was hired in December 2007, after serving 8 years as the Dental Director for Indiana's largest local health department in Marion County. In May of 2007, Rita Hope, RDH, MS, LCSW was transferred from the Office of Primary Care to the Oral Health Program (OHP) bringing community health center partnership experience and a background from a variety of dental settings. With input from oral health partners they are finalizing the draft of the Indiana State Oral Health Plan, which emphasizes increasing access to dental care for the underserved and working poor.
Oral Health Program Staff (OHPS) is restructuring the ISDH Oral Health Task Force (OHTF) and the Dental Advisory Workgroup (DAW) from the Office of Medicaid Policy and Planning (OMPP) with more community representatives to facilitate quicker results in achieving goals of recruiting more dental professionals to be Medicaid providers and enhancing dental programs to those in need. //2009//***//2010/The dental hygienist left her position in the fall of 2008. Due to budgetary issues, this position has remained unfilled. In August, 2008 ISDH received notification of grant award from HRSA. This grant award is to assist ISDH and its partners (Indiana University School of Dentistry and Indiana University Center for Health Policy) with the identification of key oral health priorities related to workforce, prevention of oral disease and infrastructure issues. One of the outcomes expected from this grant is identification of barriers to care and the development of strategies to decrease these barriers. Dr. Smith coordinated a 16 page health insert titled "Healthy Mouth, Healthy Life" which appeared in the November issue of Indianapolis Women magazine. This magazine had a circulation of over 300,000.//2010//***

In addition to their fluoridation efforts, Oral Health is the investigative authority regarding universal precautions and infectious waste management issues as they pertain to delivery of oral health services; legislatively mandated to annually survey a percentage of Indiana licensed dentists as to the effectiveness of the routine biological testing of their autoclaves; promotes the P.A.N.D.A. program (Prevent Abuse and Neglect through Dental Awareness) by providing educational presentations to local dental societies and organizations throughout the state; and provides educational materials relative to Oro-facial Injury Prevention, as requested. Additionally, MCSHC funds a grantee to provide a dental clinic for Amish children in northern Indiana to provide dental care, achieve optimal fluoridation, & increase awareness of oral health and disease./2008/ In Spring 2007 the Oral Health Program was moved under the purview of MCSHC. The Fluoridation Program was moved to the Division of Consumer Protection at ISDH. A state Oral Health Plan will be developed in December 07//2008// /2009/Indiana has long been honored for its proactive fluoride program and even though the program has moved to the Consumer Protection Department, the OHPS continues to provide technical support especially for the 30 schools which receive supplements in their water systems. MCSHC continues to partially finance the IUSD SEAL Indiana program which also has a fluoride varnish component and OHPS also monitors and shares in the data from three other sealant-fluoride programs in the state. MCSHC funds and OHPS consult grant recipients on an Amish dental clinic, a craniofacial cleft lip/palate project, and a donated dental services program for the disabled. OHPS are collaborating with Indiana University School of Dentistry Tobacco Cessation Initiative to educate on best practices and bring dental professionals up to date in their approach to pregnant women and to youth who use tobacco. ISDH and OHPS were instrumental in state rule changes bringing Indiana up to CDC recommended spore testing guidelines from every 30 days to every 7 days which began January 2008.//2009//***//2010/ISDH staff has partnered with many local communities with the promotion of water fluoridation. Several communities will receive recognition at the annual ASTDD meeting in April, 2009 for having participated in community water fluoridation for 50 years.//2010//***

MCSHC Medical Director, Dr. Judith Ganser, coordinates Addressing Asthma from a Public Health Perspective in conjunction with Indiana Department of Environmental Management. The Asthma Program organized the Indiana Joint Asthma Coalition and developed a state Asthma Plan. OMPP and ISDH provide an Asthma case management program for Medicaid clients./2007/The State Asthma Program is now fully staffed and beginning implementation of the

state Asthma Plan. The Asthma Program resides in the Chronic Disease Division of ISDH.//2007///2009/ The Asthma Program is in it's 3rd year of implementation. The updated Burden Report is available, and the Indiana Joint Astma Coalition is developing it's own website. Projects are continuing with communities, health care providers, schools, and child care providers. //2009///***2010/Indiana Joint Asthma Coalition has its own website. The Asthma Program obtained an EPA grant for home visitation and assessment in Delaware County.//2010//***

The MCSHC Adolescent Health Program works to improve Indiana adolescent health status regarding six major health risks (see YRBS below) & to increase Indiana adolescent access to primary health care services. The State Adolescent Health Coordinator manages the Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) program that includes sexual abstinence education and adolescent pregnancy prevention programming as well as providing programmatic consultation to five Title V funded school-based adolescent health centers. MCSHC works in collaboration with other public and private entities (including the American Legacy Foundation Statewide Youth Movement Against Tobacco Use) to design, develop, and implement statewide initiatives to improve adolescent health, and coordinates the collection of the Indiana Youth Risk Behavior Survey.***/2010/Due to budgetary constraints, MCSHC had to reduce the number of school-based adolescent health clinics to fund from five to three during fiscal year 2009. The Indiana Coalition to Improve Adolescent Health, facilitated by the State Adolescent Health Coordinator, has fostered collaboration with a variety of partners throughout the state to increase resources and efforts aimed at improving the health and well-being of Hoosier adolescents. The coalition has authored the state's first adolescent health plan which was published in May 2009. //2010//***

Indiana RESPECT uses State Adolescent Pregnancy Prevention funds and Federal Sexual Abstinence Education Block Grant funds to fund three components: (1) community grant program, (2) community grant program evaluation, and (3) a statewide media campaign. Specific grant applications solicit proposals for the distinct State and Federal funding programs. Grantees provide these programs in a variety of youth-serving organizations including schools, faith based organizations, and community organizations. Montgomery, Zukerman, and Davis, an Indianapolis advertising agency, will implement and measure the effectiveness of Indiana's statewide sexual abstinence and adolescent pregnancy prevention media campaign. Free broadcast-quality copies of the media materials are provided to local communities for local campaign initiatives and local media scheduling. Awareness and recall of the media campaign will be assessed by telephone surveys completed with Indiana teens and parents after each broadcast flight of the TV and radio spots./2008/Federal funding through the Abstinence Education Block Grant (AEBG) was discontinued on June 30, 2007.//2008// /2009/ The Federal Abstinence Education Block Grant was reauthorized for the fourth quarter of FY07 and on a quarterly basis for FY08 with funding currently set to terminate after the end of the third quarter, June 30, 2008. Authorization has yet to be determined for the fourth quarter of FY08. During FY08, Indiana RESPECT has partnered with the Department of Adolescent Medicine at the Indiana University School of Medicine to do an evaluation of the program specifically looking at the capacity of community-based grantees, curriculum being implemented for programming, and knowledge of participants in grantee programs through a survey.//2009///***2010/Indiana is in the process of contracting with community-based organizations to provide abstinence education programs throughout the state by using federal abstinence education block grant funds. The federal abstinence education program is currently set to expire on June 30, 2009 unless there is federal reauthorization of this program. //2010//***

MCSHC Youth Risk Behavior Surveillance System (YRBS) is part of a national survey effort by CDC to monitor student health risks and behaviors in six categories identified as most likely to result in negative outcomes. YRBS was designed to determine the prevalence of health risk behaviors among youth; to assess whether health risk behaviors increase, decrease, or stay the same over time; and to examine the co-occurrence of health risk behaviors. The categories in the survey include: Tobacco Use, Alcohol and Other Drug Use, Unintentional Injuries and Violence,

Adolescent Sexual Behavior, Weight and Nutrition, and Adolescent Physical Activity. The survey provides comparable state, and national data, as well as comparable data among subpopulations of youth. Health officials can use the data to monitor progress towards achieving the U.S. Department of Health and Human Services' Healthy People 2010 objectives, as well as to guide health programs. The sample collected for 2003 and 2005 was large enough for a weighted analysis of the data./2009/ The YRBS was successfully administered for 2007, giving a large enough sample for weighted data analysis. Indiana now has weighted data for years 2003, 2005, and 2007. The six categories of health behaviors of the YRBS were the focus of Indiana's first youth summit held in March 2008. The summit was attended by nearly 600 students from throughout the state. The summit was sponsored in part by the Indiana Coalition to Improve Adolescent Health, which the State Adolescent Health Coordinator oversees. This coalition is comprised of individuals and representatives from organizations (schools, healthcare, youth-serving organizations, etc.) across the state who share the common goal of improving the health of Hoosier adolescents. The coalition is currently working to author the state's first adolescent health plan. This plan will make Indiana a leader in the field of adolescent health, as only a handful of other states have such a plan. The plan will identify 10 priority health issues in the areas of access to care and prevention that need to be addressed for the adolescent population in Indiana.//2009//

3. CSHCN

Within MCSHC, the Children's Special Health Care Services (CSHCS) program provides financial support for primary, preventive and specialty care, including physician and hospitalization for services due to the eligible diagnosis for CSHCN statewide. The Authorization Unit completes prior authorization for services from providers. Program staff assists clients with programmatic questions and facilitates the program's services and using the Indiana Family Helpline (IFHL) for referrals to other services. CSHCS and IFHL provide access to hearing impaired and non-English speaking clients through a TTY number and translation services available within IFHL. CSHCS provides regular training to County Offices of Family and Children (OFC) staff throughout Indiana regarding the use of CSHCS services and the Enrollment Form -- a common intake for CSHCS, First Steps and Medicaid used by OFC and First Steps. This training emphasizes identification of outreach to eligible children. The CSHCS Program reimburses Family & Social Services Administration (FSSA) for local OFC staff to take CSHCS applications, gather verifications, & send applications to ISDH for eligibility determination./2007/CSHCS is beginning to implement in 2006, efforts to integrate service systems for CYSHCN. A new staff position will be created & a strategic plan developed.//2007///2008/The county OFC offices have been redesinated as county Division of Family Resources (DFR) offices. CSHCS reimburses FSSA for services involved in First Steps taking CSHCS applications, not for applications processed through DFR offices. //2008///2009/In May 2007, a manager was hired for The Integrated Community Services Program (I.G.S.) to focus on efforts around integrating service systems for CYSHCN. In February 2008, the Community Integrated Systems of Services (C.I.S.S.) Advisory Committee was developed. The committee is a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs & their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN)//2009//***/2010/In 2008 CSHCS provided training to County Offices of the Division of Family Resources (DFR) regarding the use of CSHCS services and the Enrollment Application. This training emphasizes outreach and the identification of eligible children. The local office takes applications, obtains needed verifications and sends applications to ISDH for eligibility determination by the program.The work of the CISS Advisory Committee was used to make application for HRSA/MCHB State Implementation Grants for Improving Systems of Services for CYSHCN. The grant was submitted March 2009 and Indiana is one of the recipients of a three year grant to develop an integrated system of services for Children and youth with special health care needs. //2010//***

The Hemophilia Program pays premiums for a state insurance program, the Indiana Comprehensive Health Insurance Association (ICHIA), for children and adults diagnosed with

hemophilia or von Willebrand disease who meet the program criteria. As applicable, premiums are paid by CSHCS or Chronic Disease.

a. Rehabilitation
CSHCS coordinates with the Supplemental Security Income (SSI) program to inform SSI recipients & applicants about CSHCS. CSHCS receives referrals from SSI to provide services for blind and disabled individuals under age 16 and sends information about CSHCS to those SSI recipients not already enrolled. SSI enrollment data is collected by Systems Points of Entry (SPOE) data system in First Steps & by the CSHCS HIPAA compliant data collection system, Agency Claims Administration Processing System (ACAPS), which tracks participation in SSI.

b. Community-Based Care
CSHCS customer service staff are trained insurance experts, assisting families through insurance procedures to maximize coverage and eliminate gaps in service. CSHCS works to link clients to local primary care providers and specialty providers, where possible. CSHCS works through the ASK program, formally known as the Indiana Parent Information Network, to provide assistance to families of children with special health care needs as well as to professionals to disseminate information on community resources and systems of care./2009/CSHCS customer service staff are trained insurance experts, assisting families through insurance procedures to maximize coverage and eliminate gaps in service. The CSHCS Care Coordination nurses work to link clients to local primary care medical homes and specialty care providers. They also assess the client and their family's strengths and needs and make community-based referrals to meet the needs.//2009//

CSHCS works with its community partner, About Special Kids (ASK), the place for families and professionals in Indiana to go to "ASK" questions about children with special needs and to access information and resources about a variety of topics such as health insurance, special education, community resources and medical homes.

4. Culturally Competent Care
MCSHC encourages all grantees (especially those in areas with large or growing minority populations) to work with local Minority Health Coalitions to develop culturally competent staff and materials. The ISDH Office of Cultural Diversity and Enrichment addresses the public health needs of minorities in Indiana by offering once a month two-day training session in cultural competency to all employees of ISDH and to local health professionals and grantee staff twice per month as well as a monthly advanced workshop. This office also distributes and analyzes a minority health disparity survey ISDH requires for all contractors. If contractors do not meet ISDH cultural competency goals, ISDH seeks alternate contractors./2009/ MCSHC will partner with Indiana Perinatal Network to provide three regional trainings on the "Matters of the Heart" cultural competency tool kit, and the "Learner Stance" program developed as a result of focus groups and town meetings.//2009//

The ISDH Office of Minority Health (OMH) works with state groups working with minority populations. These include Indiana Minority Health Coalition, IPN, and Indiana Latino Institute. ISDH OMH works with the Indiana Minority Health Coalition, Indiana University School of Medicine , Eli Lilly & Co., & others to increase the number of minorities drawn to health careers through scholarships, mentoring, early introduction of to health careers.
/2010/The Office of Minority Health at ISDH kicked off Minority Health Month with an opening ceremony at the Statehouse Wednesday, April 1. The Minority Health summit has been scheduled for August 17th. MCH staff will present the Life Course Perspective at the summit. //2010//

C. Organizational Structure
Section III. State Overview

C. Organizational Structure

The Honorable Mitchell E. Daniels, Jr. (R) was sworn in Jan. 10, 2005 as Indiana's 49th Governor. Daniels replaces Joseph Kernan (D) after a hard-fought gubernatorial campaign. State Health Commissioner Gregory Wilson, M.D., resigned in January. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head the Indiana State Health Department. Monroe was director of the Primary Care Center and Family Medicine Residency Program at St. Vincent Hospitals in Indianapolis since 1992. She earned her medical degree from the University of Maryland and formerly worked as director of clinics with the Indiana University School of Medicine's Department of Family Medicine. Commissioner Monroe will also serve as medical director for the state's Medicaid program. This marks the first time the two agencies responsible for regulating and paying for the health care of the state's residents have had a direct connection.

The Indiana State Department of Health (ISDH) is one of several major departments in state government. ISDH has four commissions overseen by the State Health Commissioner and Deputy Health Commissioner Sue Uhl, J.D., also appointed in February 2005./2008/Mary Hill R.N. Esq. was appointed Deputy Health Commissioner effective November 15, 2006.//2008//***//2010/Loren Robertson M.S., R.E.H.S. was appointed Deputy Commissioner in June 2009.//2010//***

The Operational Services Commission oversees three special institutions: Indiana's Soldier and Sailor's Children's Home, Indiana Veterans' Home, and Silvercrest Children's Developmental Center. Operational Services also provides Finance, Facilities Coordination and other administration for ISDH. The new Senior Director of Finance, Lance V. Rhodes, manages this commission under the authority of the Deputy Commissioner./2007//ISDH closed the Silvercrest Children's Developmental Center in May 2006. Residents have been transitioned to rejoin their families or communities.//2007///2008/ This commission has taken on oversight of the WIC Program, Legal Affairs Office, Public Affairs, Utility Services, and Vital Records.//2008///2009/ In April 2008, MCSHC was realigned from the Human Health Services Commission, which was reorganized and renamed as the Public Health & Preparedness Commission on June 1, 2008, to the Operational Services Commission (OPS), along with the Offices of Minority Health, Women Infants and Children program, and Legislative Affairs. The Information Services and Policy Commission was also renamed and reorganized to the Public Health Systems & Development & Data Commission, which houses the Epidemiology Resource Center Data Analysis Unit, Public Health Systems Development & Data Program and the Policy & Grants Management Program. //2009///***//2010/MCSHC was realigned as part of the reorganized Health and Human Services Commission under JoEllen (Joey) Vrazel, PhD, MA, Assistant Commissioner. Other divisions in the Commission include WIC, Women's Health, Nutrition & Physical Activity, and Chronic Disease.//2010//***

The Information Services and Policy Commission lead by Assistant Commissioner: Joe Hunt, M.P.H., houses Information Technology Services (ITS), Epidemiology Resource Center (ERC), ISDH Laboratories, External Information Services (EIS), Public Health Preparedness, Utility Services, Vital Records, Office of Policy, and Quality Improvement/Statistics./2008/ He is being assisted by Dr. Ted Bailey who has had much experience in laboratory medicine,public health, and preparedness.//2008// /2009/In April 2008, Loren Robertson, M.S., R.E.H.S., Assistant Commissioner of Human Health Services, assumed the oversight responsibility of the Public Health Preparedness & Emergency Response Program, now renamed as mentioned in the preceding paragraph. Dr Ted Bailey changed responsibilities to head the Response Operations Commission which provides direct oversight of the LRC Microbiology Lab.//2009//

The Health Care Regulatory Commission under Assistant Commissioner Terry Whitson, J.D., regulates Acute Care Facilities, Long Term Care Facilities, Consumer Protection, Medical Radiology Services, Sanitary Engineering, and Weights and Measures.

The Community & Family Health Services Commission houses MCSHC, WIC, Community Nutrition, Local Liaison Office with local health departments, Chronic/Communicable Disease, Immunization, Human Immunodeficiency Virus/Sexual Transmitted Disease (HIV/STD), Quality Improvement, Oral Health, and Primary Health Clinics. The new Assistant Commissioner is Loren Robertson, M.S., R.E.H.S., formerly Administrator of the Fort Wayne/Allen County Health Department./2008/ The name of the commission was changed to the Human Health Services Commission and WIC was moved to the Operational Services Commission.//2008///2009/ The MCSHC, as stated above was also realigned under OPS.//2009//

MCSHC is responsible for administering and coordinating all parts of the Title V Block Grant for Indiana. The MCSHC Administrative Director position is vacant. MCSHC Medical Director, Judith A. Ganser, M.D., M.P.H., serves as interim director along with Assistant Director Edward M. Bloom./2007/Edward Bloom has been promoted to Director of MCSHC. The new Assistant Director is Robert K. Martin.//2007//***/2010/The MCSHC Division now has separate directors for MCH and CSHCS, who report to the newly appointed Assistant Commissioner, Dr. Joey Vrazel, who heads the Health and Human Services Commission.//2010//***

MCSHC distributes Title V Federal-State Block Grant Partnership budget primarily through grants to community agencies that provide direct, enabling, population-based, and infrastructure building services that impact the federal and state performance measures.

MCSHC Health Systems Development (HSD) includes subject matter experts who coordinate several MCSHC programs. HSD works closely with MCSHC Business Management to implement parts of these programs through grants and contracts. HSD consultants provide training and technical assistance to MCSHC grantee agencies and individually facilitate programs such as Indiana Family Helpline (IFHL), Prenatal Substance Use Prevention Program (PSUPP), Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT), and the Free Pregnancy Test Program (See Section B). HSD consultants build health services infrastructure with community organizations within their assigned counties. See attached HSD consultant county assignment schedule and map. One HSD team leader also serves as MCSHC Training Manager to facilitate training opportunities for MCSHC staff, other ISDH employees and grantee staff. One HSD consultant oversees the ICCHCP and another oversees PSUPP and IFHL.

Grant programs funded by MCSHC using Title V funds include: Indiana Women's Prison Families Project, Statewide Healthy Families Abuse Prevention, Statewide Family Planning Monitoring and Data Collection, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 13 Prenatal Medical Care Clinics, 13 Infant Health Care Clinics, 15 Child Health Care Clinics, 5 School Based Adolescent Health Clinics, 4 Women's Health Care Clinics, 4 Children and Families Dental Services Programs, 23 Prenatal Care Coordination Programs, 13 Family Care Coordination Programs, 11 Family Planning Programs, 4 Childhood Obesity Programs, 5 Genetics Clinics, 3 Prenatal Genetics Programs, 2 Lead Poisoning Prevention Programs, 7 Community Needs Assessment Projects, 3 Fetal Infant Mortality Review Projects, and a number of pilot projects designed to test new approaches to health service delivery and infrastructure building. MCSHC also uses Title V to provide partial funding for several PSUPP clinics, the Indiana Poison Control Center, some RESPECT projects, prophylactic penicillin for children with Sickle Cell disease, an outreach program for Amish families with bleeding disorders, and the production of technical manuals and training programs for MCSHC staff and grantees. /2008/MCH now supports : Indiana Women's Prison Families Project, Statewide Healthy Families Abuse Prevention, Statewide Family Planning Monitoring and Data Collection, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 14 Prenatal Medical Care Clinics, 12 Infant Health Care Clinics, 12 Child Health Care Clinics, 6 School Based Adolescent Health Clinics, 3 Women's Health Care Clinics, 3 Children and Families Dental Services Programs, 26 Prenatal Care Coordination Programs, 14 Family Care Coordination Programs, 11 Family Planning Programs through a contract with the Indiana Family Health council, 1 Childhood Obesity Program, 5 Genetics Clinics, and 4 Fetal Infant Mortality Review Projects. Most special projects started in FY 2005 are now no longer receiving funds from MCH, although several of

them remain active with local funds. All Title V Family Planning services are now provided through a statewide grant //2008///***2010/ MCH now supports the Indiana Women's Prison Families Project, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 13 Prenatal Medical Care Clinics, 6 Infant Health Care Clinics, 9 Child Health Care Clinics, 6 School Based Adolescent Health Clinics, 3 Women's Health Care Clinics, 4 Children and Families Dental Services Programs, 23 Prenatal Care Coordination Programs, 10 Family Care Coordination Programs, 11 Family Planning Programs, , 4 Childhood Obesity Programs, 5 Community Needs Assessment Projects, 3 Fetal Infant Mortality Review Projects, and a number of pilot projects designed to test new approaches to health service delivery and infrastructure building. MCSHC also uses Title V to provide partial funding for several PSUPP clinics, some RESPECT projects, prophylactic penicillin for children with Sickle Cell disease, an outreach program for Amish families with bleeding disorders, and the production of technical manuals and training programs for MCSHC staff and grantees.//2010//***

Some programs including the Newborn Screening Program, Meconium Screening for Drug-Exposed Newborns Program, Newborn Hearing Screening Program, IFHL, Free Pregnancy Test and some population-based educational campaigns, including the Folic Acid Awareness Campaign, are directly administered by MCSHC. HSD and Newborn Screening are under the direction of Nancy Meade, R.D., M.P.H., MCSHC Health Planner/Programs Manager, who also co-chairs the needs assessment process. /2009/ The Genetics Services and Newborn Screening Programs have merged into Genomics and Newborn Screening Program. //2009//

MCSHC Data Analysis section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies ranging from Indiana State Police (demographic data regarding truancy and arrests of minors) to the Department of Education (school attendance and enrollment information) to all MCSHC projects and clinics (clients served in various programs) and more in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section also maintains the MCSHC portion of the ISDH web page.

MCSHC Business Management staff manages all contracts and grants, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures. This section makes Title V budget planning recommendations and coordinates all applications for funding, including primary responsibility for preparing the Title V grant application and annual report narrative. MCSHC Business Management staff coordinates all contracting, procurement and programmatic financial tracking, as well as providing a clerical support pool for the division. /2008/The Business Management section has been reorganized. Clerical support and financial tracking functions are now directly under the Asst Director. The Grant Coordinator now supervises only the Asst Grants Coordinator. The Grants Coordinator position is currently vacant.//2008// /2009/The Grants Coordinator, also known as the Business Management Manager, was filled in July 2007 by Vanessa Daniels who supervises the Assistant Grants Manager and the MCH Administrative Support Section.//2009//

The MCSHC management team consists of the Administrative Director (vacant), Medical Director (a pediatrician with a Masters of Public Health), Assistant Director, MCH Health Planner/Programs Director, Cultural Diversity & Enrichment Director, CSHCS Claims Director and CSHCS Eligibility Director. See attached organizational chart./2007/The Assistant Director has now been promoted to MCSHC Administrative Director. The new Assistant Director is Robert K. Martin, Colonel, U.S. Army, Retired. The Assistant Director directly manages the Data Analysis and Business Management sections and also supervises a Health Planner. //2007//

The Assistant Director (BS Health & Physical Education, CGSC military science graduate) w/business & automation skills coordinates personnel/facility issues & supervises the Data Analysis & Business Management team leaders. ***/2010/ As of July 1, 2009, the MCH Medical Director is also acting as MCH Director. A request to fill the MCH Director position has been submitted.//2010//***

The Data Analysis Section headed by a Public Health Administrator with a BS in Education and 20 years data analysis experience, provides data entry & analysis for MCSHC. This section includes 2 data analysis clerks & a technical consultant/web designer, as well as a data mgmt Coordinator. /2009/ An Epidemiologist for all of MCSHC is contracted fulltime and is housed at ISDH. //2009//

The Business Management Section, under a Grants Coordinator with a BS (general education) and 12 years grant management experience, coordinates contracting, financial tracking, grant application and provides a clerical pool. This section includes a Program Coordinator & Admin. Asst, w/more than 15 years exp. w/State government and three clerical/data entry staff. /2008/The Grants Coordinator position is currently vacant. The Program Coordinator position duties have been revised to serve as Assistant Grants Coordinator.//2008// /2009/ As stated up above, a new Grants Coordinator, Vanessa Daniels assumed the oversight of the Assistant Grants Coordinator and Administrative staff, no longer requiring the Assistant Director to provide direct oversight of the Business Management Section. //2009//

The MCH Health Planner/Programs Director, an RD and MPH w/more the 30 years experience in maternal and child health, supervises the MCH Health Systems Development and Genomics in Public Health / Newborn Screening section team leaders.***/2010/ The MCH Health Planner retired in May 2009. A request to fill the position has been made.//2010//***

Three HSD Teams Leaders (one with a PhD & MSW, 1 with BS in English & Psychology & 1 w/BS Public Admin) coordinate the HSD team of 3 Chief Nurse Consultants (1 RN, MSN for prenatal health, 1 RN, MS for early childhood & 1 vacant position), a MSW/LCSW HSD Consultant, the State Adolescent Health Coordinator (MPH) and the Indiana Family Helpline Program Coordinator (BA, MS, CIRS) who leads a team of 5 state and 6 contract data and clerical staff./2007/The State Adolescent Health Coordinator accepted a promotion outside of the division, and was replaced by another MPH.//2007// /2009/ The vacant Chief Nurse Consultant position has been filled. //2009//***/2010/MCH now has two Team Leaders. Due to State hiring constraints the other position can't be filled.//2010//***

The Genomics/Newborn Screening Director (MS, CGC) supervises two RN Chief Nurse Consultants, a Public Health Administrator, Social Services Specialist, Secretary and 2 clerical staff as well as a contracted State Audiologist. In addition she oversees, a Public Health Administrator who coordinates IBDPR &and the vacant State Genetics Specialist position and 2 contracted Genomics Program Consultants - 1 RD & 1 Genetics Counselor (MS, ABGC eligible). MCSHC is in process of transitioning these 2 contractors into state positions. /2009/ A new Genetics Specialist was hired in May 2007, and a contracted Cystic Fibrosis (CF) Coordinator was hired in July 2007 to facilitate the follow-up and tracking of CF positive screen infants. //2009//

The CSHCS management team includes the Eligibility Manager (RN), a Claims Manager (MA), and one RN/MSN who coordinates Prior Authorization and the cultural diversity and enrichment program, and a RN who manages the Provider Relations Section. /2008/CSHCS was reorganized to incorporate an Integrated Services Program and a separate Provider Relations Sections to implement new Indiana requirements for CSHCS providers to register to allow payment via electronic funds transfer.The revised organization of CSHCS is: MCSHC Dir. (also serving as CSHCS Dir.), MCSHC Med. Dir. (also serving as CSHCS Med. Dir.) CSHCS Program Dir. supervising the CSHCS Claims Mgr & CSHCS Systems Mgr., Integrated Services Dir., an Eligibility section, & a Prior Auth. Section.//2008//***/2010/The MCSHC Division now has separate***

directors for MCH and CSHCS, with Kate Bowen serving as the CSHCS Director, and Dr. Judith Ganser serving as the Medical Director and acting MCH Director. //2010//

D. Other MCH Capacity

CSHCN Eligibility has 2 RN Public Health Nurse Consultants, 2 RN Welfare Nurse Consultants, 2 Welfare Consultants, 8 secretaries and 2 clerical staff. Prior Authorization has 3 RN Public Health Nurse Consultants, 2 Welfare Consultants, a Social Services Specialist, Environmental Scientist and an Administrative Assistant. Claims has a Program Director (vacant), a Health Planner, 2 Social Services Consultants, 2 Program Coordinators, 2 account clerks, a Social Services Specialist, 5 clerical staff and 2 secretaries./2007/CSHCS Eligibility has 1 Program Director, 2 RN Public Health Nurse Consultants, 2 RN Welfare Nurse Consultants, 2 Welfare Consultants, 8 secretaries and 4 clerical staff. Prior Authorization has 1 Program Director, 2 RN Public Health Nurse Consultants, 6 Nurse Consultants, and an Administrative Assistant. Claims has 1 Program Manager, 1 Program Director, a Health Planner, 7 account clerks, and 1 secretary. Provider relations has 1 Program Director, 1 Social Services Specialist (vacant), 1 Program Coordinator, 1 Account Clerk and 1 Secretary (vacant).//2007//
/2008/CSHCS re-aligned positions internally. Eligibility now has 1 RN Public Health Nurse Consultant, 2 RN Welfare Nurse Consultants, 1 Welfare Consultant, 8 eligibility clerks, and 4 clerical assistants. The Director of Claims also serves as director of Systems with 1 health planner and 1 program coordinator, and Director of Administration section with 1 administrative assistant. There are 6 clerical assistants.//2008///***2010/Current staffing for the CSHCS Program includes the CSHCS Director, 5 managers (Provider Relations, Claims, PA, Eligibility and Systems), and a Program Coordinator 3 who supports the director and the PA Section. CSHCS currently has 3 nurses in the Eligibility Section and 4 nurses in the Prior Authorization Section. Current plans include filling two nurse vacancies in the PA Section in FY 10. Additional staffing includes 4 Eligibility coordinators, 5 Re-evaluation coordinators, 3 Provider Relations specialists, PR secretary, 2 administrative support staff, Claims secretary, 2 Claims account clerks (includes 2 vacancies currently, one of which is being filled), 4 claims processors, 1 Business Administrator (not filled) and 1 Claims Administrative Assistant. CSHCS is supported by the MCSHC Medical Director and contracts with a physician consultant for review of some medical questions.//2010//***

MCSHC staff includes approximately seven parents or grandparents of children with special health care needs. Two are in NBS and four are part of the IFHL, including the IFHL coordinator. MCSHC, through a contract with the Indiana Perinatal Network, Inc., supports a SIDS parent who runs the SIDS program in Indiana. A contract with Indiana Parent Information Network also supports parent involvement./2008/ Indiana Parent Information Network has changed their name to About Special Kids (ASK)//2008///2009/The About Special Kids (ASK) contract supports parent involvement by using trained and experienced Parent Liaisons to provide peer support, information and referral and education and training for families of children with special health care needs. Activities include sending a monthly e-newsletter, developing and sending out educational materials, operating an information "hotline" and a system of follow-up contact with families, conducting training sessions, and assessing the ongoing and changing needs of families with special health needs. ASK, utilizes family input to develop strategies to address issues such as childcare, community resources, early intervention, health care financing, relocation and children's rights.//2009///***2010/ASK provided support to over 9,000 families/providers in FY 2009.//2010//***

MCSHC also supports one dentist, a dental hygienist, four fluoridation staff and two secretaries in the Oral Health Program; one lawyer in ISDH legal department; two Information Technology Services staff plus three contractual positions in ITS; and one Epidemiology Resource Center professional./2007/In FY 2007, MCSHC supports the following staff outside of the division: two clerical and five professional Oral Health Services staff, three Information Technology staff and four IT contractors, an epidemiologist (vacant) and two contracted epidemiologists, the director of Community Nutrition and Obesity Prevention (a MPH), two laboratory staff (a microbiologist and a

chemist) one clerical staff and four professional/administrative staff for the Lead Poisoning Prevention Program as well as the Lead Poisoning Prevention Director.//2007///2008/The Director of Oral Health position, which is currently vacant, now reports to the MCSHC Director. See section D. //2008///2009/ New Oral Health Program Director, Dr. Kent Smith, was hired in December 2007. Dr. Smith has 12 years experience in community health most recently as Director of the Marion County (Indianapolis) Health Department Dental Program. //2009///***2010/A request has been made to state Personnel to fill the now vacant dental hygienist position.//2010//***

E. State Agency Coordination

Public Health Relationships

The public health system in Indiana includes ISDH and 94 autonomous local health departments (LHD) that are functions of county or municipal government. MCSHC coordinates with the ISDH LHD liaison office & local health departments to facilitate development of health systems in counties of need. MCSHC provides Title V funding to Marion, Lake, St. Joseph, & Madison counties for FIMR projects. Title V funding to other LHD MCH programs promotes direct services clinics, enabling case management services, infrastructure building services and population based services through free pregnancy testing programs & media campaigns.

ISDH MCSHC works with other parts of ISDH through informal and formal staff assignments, collaborative initiatives, technical assistance, development of policy, state plans & funding of programs. These include coordination with the Lead Prevention Program to develop policy & programs & Title V funding of a prenatal lead testing program, sitting on the State Immunization Program Committee, funding of the statewide Dental Sealant Program, & population based surveys through the Oral Health Department & the IU School of Dentistry, sharing of educational materials, & providing technical assistance to the Division of HIV/STD, Office of Cultural Diversity and Enrichment to provide mandatory cultural competence trainings for all Title V funded projects, Newborn Screening, co-location of clinics & shared funding with the Office of Primary Care and work to integrate MCSHC programs with FQHC & CHC programs, and WIC and Community Nutrition programs to develop a state breast feeding plan, chronic disease asthma program, & a state obesity prevention program./2007/MCSHC provides funds to support several initiatives under the Community Nutrition and Obesity Prevention Division.//2007///2008/Oral Health Director position is currently vacant and the MCSHCS Medical Director is acting State Oral Health Director. A state breastfeeding plan was developed.//2008// /2009/ MCSHC Services through an Indiana Perinatal Network contract supports the State Breastfeeding Coordinator who is to facilitate the implementation of the State Breastfeeding Plan and staff the Indiana Breastfeeding Alliance. //2009///

MCSHC also works with ISDH departments outside of the Community and Family Health Services Commission including collaboration with Epidemiology staff to develop the Operational Data Store (ODS) to create a common health status database to collect health status and services information across several program areas & provide for more comprehensive data analysis, Vital Records, the Office of Minority Health to address disparity issues, & the Office of Women's Health education and planning./2008/Commission name is Human Health Services.//2008//
/2010/MCH & Office of Women's Health had a day long retreat to improve coordination & decided on some mutual priorities such as decreasing prematurity.//2010//

MCSHC has an ongoing relationship with the Bioterrorism Preparedness Program within ISDH. MCSHC collaborated with the ten public health preparedness district epidemiologists to collect assessment data on each county and Systems Development consultants were reassigned counties to correspond with ten public health preparedness districts./2007/The FY 2007-2008 MCH Grant Application Procedure requires applicants to coordinate activities with local and regional health emergency preparedness coordinators.//2007///2008/The MCSHC Medical Director has discussed the issue of preparedness for pregnant women, infants and CSHCN with

the ISDH Preparedness Program, and will be working with Indiana Chapter of March of Dimes to raise awareness about preparedness for pregnant women around the state. They will be setting up plans for vulnerable populations this year. //2008///2009/ MCSHC Medical Director gave five talks around the state regarding disaster preparation for pregnant women, infants, children, & children with special health care needs. //2009///***2010/MCSHC Medical Director is working with ISDH Preparedness Program to prepare for the return of H1N1 in 2009 particularly among pregnant women, infants, and children with underlying chronic conditions.//2010//***

MCSHC provides partial funding for the Indiana Poison Control Center (IPC), operated by Clarian Health Partners. IPC provides statistical data to MCSHC & also by contract provides epidemiological surveillance for potential bioterrorism or chemical disaster clusters by region, nature & frequency of incident reports./2008/State Department of Health is paying for the Indiana Poison Control Center with tobacco funds for 2008.//2008///***2010/MCH no longer funds the (IPC) as of 2008//2010//***

Relationships with Social Services
The Indiana Family and Social Services Administration houses the Division of Family Resources which encompasses Temporary Assistance to Needy Families (TANF), food stamps, child care, foster care, adoption, homeless services, and job programs; the Division of Disability and Rehabilitative Services which encompasses in-home services, deaf and hard-of-hearing services, blind and visually impaired services, and social security disability eligibility; the Division of Mental Health and Addiction, and the Office of Medicaid Policy and Planning.

ISDH and FSSA share data through a Memorandum of Understanding (MOU) that addresses general areas of collaboration and data interchange as well as specific issues like reimbursement for lead lab tests and IFHL outreach for FSSA services for children with special health care needs who are eligible for both Hoosier Healthwise and CSHCS. This includes eligibility for SSI through the FSSA Disability Determination Bureau and services through the FSSA Vocational Rehabilitation Services.

MCSHC coordinates with Indiana Family and Social Services Agency (FSSA) to expand Hoosier Healthwise (Medicaid) coverage, develop comprehensive early child care systems including the Early Childhood Comprehensive Systems Program (ECCS) & the Indiana Child Care Health Consultant Program (ICCHCP), provide partial funding for the Healthy Families program & receive funding for the PSUPP./2007/The ECCS program was renamed "Sunny Start: Healthy Bodies, Healthy Minds".//2007///2008/The Sunny Start project manager serves on the Head Start Collaboration Office Advisory Council. //2008///***2010/ The Sunny Start project manager now serves on the Paths to Quality (Indiana's child care provider Quality Rating System) Provider Resources and Professional Development Committee//2010//***

The MCSHC Medical Director serves on the First Steps Interagency Coordinating Council and the Board for the Coordination of Child Care with FSSA staff and other state agencies and consumers./2007/The Board for Coordination of Child Care has been replaced by an advisory board made up primarily of child care providers.//2007//

ISDH and FSSA coordinate with WIC, CSHCS and First Steps to reduce duplication and ensure coverage for all eligible infants & children. CSHCS & FSSA provide joint planning, outreach and training for county systems points of entry to determine Medicaid and/or CSHCS eligibility. MCSHC standards of care for prenatal care coordination & child health programs require developmental screening and referral to First Steps for children age 0-3.

MCSHC staff serves on FSSA's Indiana Head Start Partnership Project Advisory Council. Federal funding from DHHS, Administration for Children & Families has enabled Head Start programs to provide comprehensive services for low-income Hoosier children and their families for over 35 years./2007/The Indiana Head Start Partnership has been renamed the Indiana Head Start

Collaboration Office.//2007//

MCSHC requires all grantees to provide EPSDT & accept funding from Medicaid as payment in full. Medicaid provides reimbursement for EPSDT.

MCSHC houses the Prenatal Substance Use Prevention Program (PSUPP) with partial funding from Title V, FSSA Division of Mental Health and Addiction, and Indiana Tobacco Prevention and Cessation (ITPC). PSUPP works to prevent poor birth outcomes by helping women to decrease or cease alcohol, tobacco & other drug use during pregnancy. PSUPP is implemented statewide through the efforts of a MCSHC state program director, twenty local directors & an evaluation team. The local directors collectively serve, but are not limited to, constituents from twenty-two Indiana counties that include: Allen, Clark, Dearborn, Dubois, Delaware, Elkhart, Franklin, Jennings, Lake, LaPorte, Madison, Marion, Ohio, Owen, Putnam, Ripley, Spencer, Switzerland, Tippecanoe, Vanderburgh, Vigo, & Warrick./2007/Pike, Grant, and St. Joseph counties have been added for a total of 25.//2007///2008/House Enrollment Act 1457, effective July 1, 2007, establishes the Prenatal Substance Abuse Commission to develop a plan to improve early intervention and treatment for pregnant women who abuse alcohol, tabacco, or drugs. This commission is to convene before October 15, 2007.//2008///2009/Substance Abuse Commission convened on October 7, 2007, has met two additional times and has three working committees to develop the plan.//2009///***2010/The Commission has continued to meet bi-monthly, with its three sub-committees meeting on an as-needed basis. An interim report was drafted in August, 2008 and submitted to the legislature. The report made preliminary recommendations for strategies & the funding needed to implement them, based on the findings of the sub-committees.//2010//***

MCSHC supports efforts to promote education and screening for perinatal depression. The Indiana Perinatal Network received a three-year continuation grant from HRSA to develop a perinatal depression state plan, including provider training and protocols./2007/Indiana Perinatal Network will be facilitating the second regional perinatal depression summit and certificate of completion course in Bloomington , in August 2006. The "Decision Tree for Depression During the Childbearing Years", a tool to assist professionals in identifying, treating, and referring women for post partum depression has been added to the IPN website and can be downloaded for use by professionals. For consumers, "Something Isn't Right: Do You Have Depression" has been added to the IPN website and includes the Edinburgh Screening Test that is taken & scored online. Women with a high score placing them at risk for suicide are referred to their ER.//2007///***2010/During 2009 Indiana Perinatal Network will present trainings on Perinatal Mood Disorders in Lafayette, June 17, Newburgh, July 22, and Monticello, September 18th.//2010//***

MCSHC provides partial funding for Healthy Families Indiana (HFI), a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education available in all 92 counties. Part of Healthy Families America, HFI provides support to families with their first newborn whose hospital or prenatal screens indicate that they are at risk for child abuse. HFI is also funded by FSSA and the Indiana Criminal Justice Institute and receives additional support through TANF funds, a specialized license plate, Kids First, and other sources.

MCSHC receives funds from FSSA to coordinate the ICCHCP that provides consultation on health and safety issues to child care providers by site visit and phone and provide health and safety information, educational materials and contact information via the internet, access to resources, reports and data on the website./2007/Pilot projects in Lake (Gary) Dubois and Lawrence counties provide a greater concentration of services for providers of child care. The pilot will also focus on involving medical and health service providers in the support for child care.//2007///2008/The program will transistion in September 30, 2007 when FSSA resumes responsibility for child care health consultation in conjunction with the newly developed Quality

Rating Systems program to be rolled out in January 2008.//2008//

The new State Health Commissioner also serves as Medical Director for the State Medicaid program--appointed to that position by the Governor to better coordinate ISDH and Medicaid policy. MCSHC coordinates with FSSA Office of Medicaid Policy and Planning (OMPP) to expand Hoosier Healthwise (Medicaid) coverage. Many Title V grantees became Medicaid enrollment centers for Hoosier Healthwise when the State expanded the program for SCHIP. /2009/ MCSHC staff are working with several Office of Medicaid Policy and Planning Committees. The MCSHC Medical Director participates in the Medicaid Quality Strategy Committee (QSC). ISDH and OMPP are working on a procedure to match birth certificate data with Medicaid perinatal outcome data. The State Health Commissioner is a member of the Medicaid Policy Advisory Committee (PAC) and the MCSHC Medical Director serves on the PAC working group. //2009//***//2010/ISDH & OMPP have matched data to study perinatal risk factors & outcomes.//2010//***

As of July of 2005 all Indiana Medicaid participants, except those with disabilities in the Medicaid Select program will be enrolled in mandatory Medicaid Managed Care Organizations (MCOs). OMPP has contracted with five MCOs to cover the state. MCSHC has been working with OMPP and the MCOs to ensure that targeted case management services remain available to meet the needs of pregnant women, infants and families.

Indiana Prenatal Care Coordination (PNCC) identifies pregnant women who are eligible for Title XIX and Title XXI and helps them apply for services. PNCC has been a Medicaid reimbursable service in Indiana since 1990. Services include outreach and case finding, home visit assessments per trimester, care plan monitoring, education, and referral to needed services. MCSHC funds local agencies and hospitals to provide prenatal care coordination in areas where mothers are at high risk for poor pregnancy outcomes. MCSHC provides technical assistance, training and oversight to funded and non-funded prenatal care coordination programs in Indiana. MCSHC works closely with the federally funded Healthy Start Programs outreach and case management initiatives in Indianapolis and Lake County./2008/House Enrolled Act 1678 signed into law on 6/7/07 increases coverage of pregnant women from 150% FPL to 200% FPL and allows presumptive eligibility for pregnant women limited to ambulatory prenatal care. In 2007 Indianapolis has modified the South Bend faith based model and uses pastor's wives or "First Ladies" to provide health education to the congregation.//2008//***//2010/Presumptive eligibly will roll out July 1, 2009. MCSHCS is collaborating with the Office of Medicaid Policy and Planning to implement presumptive eligibility in all Title V funded prenatal clinics and Community Health Centers. //2010//***

MCSHC collaborates with the Indiana Chapter of the National Association of Social Workers to provide certification training to nurses and social workers applying to become prenatal care coordinators.

With the entrance of Medicaid Managed Care in Indiana MCSHC found the PNCC program in jeopardy as MCOs wanted to provide care coordination services over the phone. MCSHC staff met with OMPP and the MCOs to assure that the Medicaid PNCC continued to be utilized and continued to receive reimbursement for services as stated in Indiana Code 405 IAC 1-7-24./2007/Ongoing meetings with all MCOs continue. MCO PNCC Operational Guidelines were finalized April 19, 2006 and will be a part of MCO contracts with prenatal care coordinators.//2007//

MCSHC staff collaborated with OMPP and the MCOs to revise the State Prenatal Risk Assessment Tool, and works to standardize assessment and report tools, revise training of prenatal care coordinators, program evaluation, and also participates in the revision of the Medicaid Code on prenatal care coordination reimbursement. At least three training events, directed to local prenatal care coordination providers, are planned in cooperation with OMPP and the MCOs to educate providers on new tools, how to contract with MCOs, billing and reimbursement under MCOs./2007/Standardization of assessment forms developed in

collaboration with MCSHC, MCOs & prenatal care coordinators were completed and released in a Medicaid Bulletin in March, 2006. 3 regional trainings on use of the standardized forms were provided by MCSHC in May, 2006. 4 of the 5 MCOs attended one or more of the trainings to share their programs with Prenatal Care Coordinators and to facilitate initiation of contracts.//2007///***2010/The state prental care coordination program is being restructured due to new rules from CMS, OMPP and the MCOs. The Prenatal Care Coordination program will now be called Indiana Healthy Beginnings. //2010//***

Relationship With Other State Agencies
MCSHC funds Indiana School for the Deaf (ISD) to support EHDI programs by providing training materials, a video project and regional audiologists to outreach to hospitals, audiologists and First Steps programs statewide to identify, promote, support and educate families with infants newly diagnosed with hearing loss in language development./2007/ISDH now contracts directly with regional audiologists, but continues to support other ISD initiatives.//2007/***2010/The ISDH EHDI program works closely with the Part C (First Steps) program, which is within the Family and Social Services Administration (FSSA), to ensure that children are appropriately referred to First Steps for follow-up services. EHDI staff meet regularly with the Part C Coordinator, communicate with the directors of the nine First Steps regional offices across the state, and provide inservice education to First Steps Intake and Service Coordinators as well as First Steps Direct Service Providers of audiology and early intervention. ISDH also collaborates with the Indiana School for the Deaf (ISD) in the delivery of the SKI*HI program, a family education curriculum that is provided through ISD's Outreach Program. ISDH provides annual funding for curriculum materials. //2010//***

MCSHC receives funds from Indiana Department of Education (IDOE) to perform the Youth Risk Behavior Study (YRBS) to identify and reduce high-risk behaviors among school age children. ISDH partners with IDOE to improve the health of Indiana children through the schools. IDOE has received a 5-year grant from the Centers for Disease Control and Prevention to bring the Coordinated School Health Program model to Indiana. The grant includes staff members in both state agencies./2008/In 2007, ISDH collected data for the YRBS which has been sent to CDC for analysis. It is unknown at this time whether Indiana will have weighted data again.//2008///2009/ The YRBS was successfully administered for 2007, giving a large enough sample for weighted data analysis. Indiana now has weighted data for years 2003, 2005, and 2007. The MCSHC will assist with the administration of the 2009 YRBS which will be organized by the Indiana Department of Education.//2009// ***/2010/The administration & responsibilities of the 2009 YRBS have been transitioned from the Indiana Department of Education to the Indiana State Department of Health (ISDH). ISDH intends to conduct a Fall 2009 administration of the YRBS.//2010//***

MCSHC provides technical assistance for school programs, policy and environmental change, educational strategies based on CDC guidelines and coordination of resources. This program has eight interactive components: Health Education, Physical Education, Health Services, Nutrition Services, Counseling, Psychological, & Social Services, Healthy School Environment, Health Promotion for Staff, & Family/Community Involvement. The key focus areas are obesity, nutrition, physical activity, chronic disease, & alcohol, tobacco, & other drugs./2007/The office for the Coordinated School Health Program is under the Deputy Health Commissioner, but MCSHC is part of the internal steering committee.//2007///2009/ Indiana was not refunded for the next five year Coordinated School Health Program grant from the CDC. This has been a collaborative effort between the Indiana State Department of Health, MCSHC, and the Indiana Department of Education.//2009//

MCSHC has developed a coalition that includes IDOE, to implement the Early Childhood Comprehensive Systems program to create an integrated, coordinated, comprehensive system of services for children from birth to five. This initiative will help to ensure that a holistic system of care supports young children so they arrive at school ready to learn./2007/The Sunny Start: Healthy Bodies, Healthy Minds Program (formerly the ECCS) Grant was funded by the Maternal

and Child Health Bureau for 2 years of planning activities that began in 2003.//2007//

MCSHC works with the Indiana Department of Corrections through coalitions, & programs that provide services to prevent child abuse such as IHF, & the ICCHCP. MCSHC funds the Indiana Women's Prison's Responsible Mothers/Healthy Babies program to build & preserve the mother/child/family bonds while women are in prison.
/2009/ This year, the Women's Prison program expanded to include the Wee Ones Nursery, which allows carefully selected offenders to return to the prison with their newborns. Indiana is only the 7th state in the country to establish such a program.//2009//***/2010/ The nursery has been a great success and was even featured in an article in Newsweek magazine in May 2009 (http://www.newsweek.com/id/197275).//2010//***

Relationships With Universities
Over the years MCSHC has developed a relationship with the Indiana University Schools of Medicine and Nursing, & the new Department of Public Health. MCSHC collaborates with the Indiana Perinatal Network (IPN) & with these educational institutions to develop, sponsor, and coordinate training events for health care professionals in public and private health settings./2008/The Marion County Health Department, ISDH MCSHC and IPN sponsored a one day conference on Prenatal Substance Abuse with speakers from Indiana University School of Medicine in Fall 2006. There will be an Unintended Pregnancy Summit sponsored by IPN and ISDH in September 2007. The Sunny Start (ECCS) Program is sponsoring a week long Institute on Infant & Toddler Mental Health in collaboration with Faculty from IUSM Department of Behavioral Pediatrics on July 9-13, 2007.//2008//***/2010/ Sunny Start continued to collaborate with the IU School of Medicine to partially fund a Medical Home project, sponsor a one day conference providing training in early mental health services delivery and expand mentorship programs for mental health providers.//2010//***

MCSHC contracts with IU professors to evaluate pilot programs and conduct focus groups and town meetings around the issue of perinatal disparities. MCSHC has a long relationship with the IU Bowen Center to provide statistical evaluation of the PSUPP program & other funded initiatives. This year the Director of Adolescent Medicine will evaluate Indiana's RESPECT programs./2007/The evaluation is on hold due to funding constraints.//2007//***/2010/As a result of a partnership between the Indiana University School of Medicine, Section of Adolescent Medicine & Indiana RESPECT, an evaluation of state-funded programs to provide abstinence & teen pregnancy prevention programs was conducted during fiscal year 2008. The report provided valuable insight & recommendations for consideration in future distribution of state funds for abstinence education & teen pregnancy prevention programs.//2010//***

MCSHC links with state universities through the Masters of Public Health Program at Indiana University (IU) & the Center for Public Health Leadership and Education. Medical students from the IU Medical School are provided with preceptors for a public health rotation. Riley Infant and Childhood Nutrition Fellows at Clarian's Riley Hospital for Children are provided Title V background information. The MCSHC Medical Director serves on the advisory board for the MCHB funded Adolescent Health Training Program, Riley Child Development Program, and Behavioral Pediatrics Program./2007/MCSHC works closely with Purdue University in regards to the Folic Acid Program and Indiana Suicide Prevention Coalition.//2007// /2009/ ISDH has developed a month long rotation in Public Health for physicians in primary care residency training programs.//2009//

MSCHC works with IU School of Dentistry (IUSD) to provide the statewide Dental Sealant Program. Title V and Children's Oral Healthcare Access Program (COHAP) funds support a mobile dental unit to provide school-based dental sealants in rural areas, particularly those near community health centers. Student dentists & hygienists staff the unit. MCSHC also provides funds to IUSD to support the craniofacial reconstructive surgery unit for children born with dental deformities including cleft palate.

Indiana Minority Health Coalition
MCSHC collaborates with the Indiana Minority Health Coalition (IMHC) to provide consultation for MCSHC grantees. MCSHC funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Through 15 local Minority Health Coalitions, IMHC provides an immunization outreach program that works with local health departments and MCSHC projects to provide immunizations & health care. The IMHC Director also serves on the Steering Committee of Core Partners for ECCS.

MCSHC collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meetings, work with faith based organizations to provide culturally competent services to African American families.

Helpline
MCSHC Indiana Family Helpline (IFHL) is a partner in IN211, Inc. IFHL and MCSHC staff have participated in the development of IN211 because IFHL is the only statewide I&R service. IFHL also assists the IMHC hotline by providing the database software & data./2008/The IFHL will work to become an 211 call center by December 2008.//2008//***/2010/Due to funding contraints IFHL has delayed becoming an IN-211 call center.//2010//***

Indiana Perinatal Network
MCSHC implements several programs through the Indiana Perinatal Network, Inc (IPN). These include the Indiana Perinatal Systems Strategic Plan for the 21st Century, developed through a series of regional town meetings and state task force groups. IPN builds infrastructure, provides professional and public education on perinatal health issues and quality assurance standards of care for perinatal services in Indiana. IPN houses the Sudden Infant Death (SIDS) program and the MCSHC Breastfeeding Program and provides a statewide Advisory Board for program planning, Regional Perinatal Advisory Boards, a speaker bureau, & multi-media public education campaign. IPN also publishes Indiana Perinatal News (IPN newsletter), the Indiana Prenatal Online Magazine http://www.indianaperinatal.org, consumer information, clinical practice alerts, critical reports, and consensus documents like the Indiana Prenatal Guide. MCSHC also funds IPN to operate a pilot project to provide and evaluate Doula services in Marion County and the Indiana Friendly Access program to identify best practices to increase satisfaction with and utilization of health care services for low income pregnant women and children and to more clearly identify and address barriers to health care for pregnant women and families with young children./2009/ IPN will complete the hospital survey regarding regional perinatal care in FY2008 & begin the training necessary to develop a regional perinatal system in FY2009.//2009//***/2010/The Levels of Hospital Perinatal Care in Indiana was completed in Oct. 2008//2010//***

Tertiary Care Centers
MCSHC funds a CSHCS satellite office at Riley Hospital to provide CSHCN & their families easily accessible & expedited entry to the CSHCS program. MCSHC funds the Riley Hospital Comprehensive High-Risk Newborn Follow-up Program to provide follow-up to children and their families who are at the highest risk, medically & developmentally, of morbidity or mortality and build community-based infrastructure for these fragile children./2009/MCSHC funds a Care Coordination nurse practitioner (NP) for the Spina Bifida (SB) Program at Riley Children's Hospital. The SB Clinic serves over 500 children & adolescents with SB or related spinal problems from all areas of the state. MCSHC funds The Center for Youth and Adults with Conditions of Childhood (CYACC), a Transition Clinic that assists youth with chronic conditions of childhood integrate into the adult world. The clinic's Bridging Team links Youth with Special Health Care Needs (YSHCN) to a primary care Medical Home using an identified model of practice-based care coordination, community outreach & interagency collaboration to meet the youth & family's needs. The Bridging Team has the expertise and accessibility to be a resource

for families and health care providers throughout the state. Social Workers at Lutheran Hospital, Ft. Wayne-IN, Clarian North Hospital, Carmel-IN, St. Joseph Memorial Hospital, South Bend-IN and Cincinnati Memorial Hospital for Children in Cincinnati, Ohio take CSHCN applications & are also kept up to date on changes to the application process. St. Vincents Hospital opened the Peyton Manning Children's Hospital that provides some tertiary care. //2009//

IPN in collaboration with ISDH, ACOG (American College of Obstetricians and Gynecologists), the State Perinatal Advisory Board and Indiana hospitals that provide perinatal health care, developed a consensus statement on Levels of Hospital Perinatal Care in Indiana to establish criteria for risk-appropriate levels of hospital obstetric and neonatal care and provide recommendations for appropriate consultation, referral & transport. There are a total of five full Level III Obstetric Hospitals in Indiana: IU Hospital, Methodist Hospital, St. Vincent Hospital, & Wishard Hospital in Indianapolis, & Memorial Hospital in South Bend. Riley Children's Hospital and St. Vincent Hospital in Indianapolis have the only two Level III/D Neonatal Intensive Care Units in the state. However, a total of six other hospitals are considered Level III/Subspecialty B-C. These are located in Indianapolis, South Bend, Evansville, Newburgh, Muncie and Fort Wayne.The Level I & II hospitals are encouraged to create a MOU with the tertiary hospital to stabilize & transport high risk pregnant & neonates.

F. Health Systems Capacity Indicators

Introduction

/2010/ The Health Systems Capacity Indicators are each updated in the detailed sections following //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	29.6	28.9	25.0	23.8	22
Numerator	1276	1243	1076	1041	
Denominator	430557	430439	431089	437494	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Projection made based on prior years' data.

2008 data not yet available. Source will be ISDH Asthma (Chronic Disease Program).

Notes - 2007

Source of data: ISDH Asthma (Chronic Disease Program)

Notes - 2006

Source of data: ISDH Chronic Disease Program

Narrative:

Notes - 2008

Data unavailable; provisional data provided by ISDH Chronic Disease Program.

Notes - 2007

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2006

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2005
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2004
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2003
Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Narrative:
#01 HEALTH SYSTEMS CAPACITY INDICATOR The rate of children hospitalized for asthma (10,000 children less than five years of age)

Since 1990, the prevalence of asthma for children 18 and under has doubled in Indiana, and currently 8% of all Hoosiers have asthma, placing Indiana 14th in the nation in asthma prevalence.(L. Stemnock and J. Lewis, "Asthma Prevalence in Indiana,"Indiana State Department of Health (ISDH) Epidemiology Resource Center/Data Analysis Unit, 2001). However, the rate of Indiana children less than five years of age hospitalized with asthma has decreased from 38.7/10,000 in 2003 to 29.6/10,000 in 2004. This data was obtained from Indiana Hospital Discharge Data through the ISDH Epidemiology Resource Center. The reason for such a major reported decrease is greatly improved data from the Health and Hospital Corporation of Marion County, whose discharge data was until 2003 based on projections that were overstated. Now that we have established a reliable means of getting accurate data, we will use 2003 as a baseline.

In October 2002, the ISDH and the Indiana Department of Environmental Management (IDEM) were awarded interagency funding by the Centers of Disease Control and Prevention's (CDC) National Asthma Program for capacity building and asthma plan implementation.

In December 2004 the Indiana Joint Asthma Coalition, ISDH and IDEM published A Strategic Plan for Addressing Asthma in Indiana, a five-year strategy to begin addressing the burden of asthma in Indiana that includes a data surveillance plan. Currently, Indiana asthma surveillance involves the collection of prevalence, severity, and cost data using the Behavioral Risk Factor

Surveillance Survey (BRFSS), Medicaid claims data, hospital discharge data, and mortality statistics. Each of these data sets has inherent limitations. For example, the BRFSS gives us data on adults only, patterns of health care are limited to Medicaid recipients, and hospital discharge data prior to 2002 was not individually identifiable which prevents trend analysis of hospitalizations.

The Data and Surveillance Workgroup of the Indiana Joint Asthma Coalition (IJAC) will work toward identifying gaps in present data sources describing the asthma burden and accessing additional data sources. Strategies of the workgroup include: 1) Solicit, inventory, and review the data needs, 2) Identify key users of asthma data in Indiana and review their data needs, 3) Identify gaps in present data collection and identify potential data sources to fill these gaps, and 4) Establish standardized data definitions, data analysis methods, and surveillance standards, utilizing nationally recognized definitions as applicable. In addition the workgroup will include geostatistical (GIS) analysis, the linkage of asthma prevalence with environmental data, and schools response in preventing and responding to asthma among students.

In 2005 and 2006 the IJAC continued to work on identifying gaps in data sources. Using the same strategies formulated in 2005 (above), the Data and Surveillance Workgroup was able to provide ever more accurate data.

/2009/ In 2007 this has continued, while additional techniques and strategies discussed earlier have begun to be explored more more fully (e.g., exploring more uses for GIS analysis, linkage of asthma prevalence with environmental data). It is hoped that information gathered using these strategies will decrease data gaps and continue to increase accuracy in 2008. //2009//

/2010/ Methods listed in 2009 were continued. Further detail related to this HSCI can be found in Narrative Overview Section IV D, State Performance Measure #2. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	65.6	61.4	83.4	83.2	83.4
Numerator	53875	52964	44186	43067	43048
Denominator	82169	86298	52965	51784	51593
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data provided By OMPP using their new data system.

This system has been revised and is finally providing comprehensive data as of FY2008. Efforts to run reports for the past two years are being made. Until that time, projected data calculated using the previous data supplied by Medicaid and the current 2008 data has necessitated a change in the 2006 data and given projections for 2007.

Source of data: OMPP

Notes - 2007
Data provided By OMPP using their new data system.

This system has been revised and is finally providing comprehensive data as of FY2008. Efforts to run reports for the past two years are being made. Until that time, projected data calculated using the previous data supplied by Medicaid and the current 2008 data has necessitated a change in the 2006 data and given projections for 2007.

Source of data: OMPP

Notes - 2006
Data provided By OMPP using their new data system.

This system has been revised and is finally providing comprehensive data as of FY2008. Efforts to run reports for the past two years are being made. Until that time, projected data calculated using the previous data supplied by Medicaid and the current 2008 data has necessitated a change in the 2006 data and given projections for 2007.

Source of data: OMPP

Narrative:
Notes - 2008
Source of Data: OMPP.

Notes - 2007
OMPP was able to provide provisional data.

Notes - 2006
After further revisions of the new data system at OMPP, a far more accurate numerator was submitted to ISDH. Therefore, rather than 2005, it will be 2006 data that will be used as base year data.

Notes - 2005
Data provided By OMPP using their new data system. This should be treated as base year data.

Notes - 2003
Source of Numerator & Denominator: Office of Medicaid Policy & Planning.

Narrative:
The percent of Medicaid enrollees whose age is less than one year during the reporting year who received one initial periodic screen.

The percent of Medicaid enrollees whose age is less than one year during the reporting year that received one initial periodic screen was reported by Medicaid as 65.6% for 2004. Medicaid's modifications to their computer system eliminated some unintentional duplication present in 2003's figures. Indiana mandatory Managed Care for the MCH Medicaid population began phase-in transition in 2002. Managed Care prenatal care providers have been encouraged to assist the mother with enrollment of the baby with a managed care provider prior to delivery.

In July 2005, five Medicaid Managed Care Organizations (MCOs) will cover all 92 counties in Indiana and will provide services for all Medicaid participants except those in Medicaid Select. The Indiana Prenatal Care Coordination program, and Healthy Families work closely with the MCOs and also assist in getting the infant into primary care. Performance data specific to each of the Hoosier Healthwise risk-based managed care plans will be published yearly by the Office of

Medicaid Policy and Planning (OMPP).

In 2006, OMPP made significant changes to their data system. This enabled them to provide ISDH with what they concluded were far more accurate figures in many areas, including HSCI2.

/2009/ In 2007, after a further major change to OMPP's data system, eliminating duplicates and using more accurate techniques, OMPP provided new and signficantly different figures for the numerator which thus affected the annual indicator greatly. This should be treated as new base year data. This is projected to remain the same for the next year //2009//

/2010/ Methods listed in 2009 were continued. Data provided By OMPP using their new data system. This system has been revised and is finally providing comprehensive data as of FY2008. Efforts to run reports for the past two years are being made. Until that time, projected data calculated using the previous data supplied by Medicaid and the current 2008 data has necessitated a change in the 2006 data and given projections for 2007. Source of data: OMPP. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	14.2	12.1	91.7	91.7	91.7
Numerator	225	186	88	88	88
Denominator	1581	1531	96	96	96
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2008
Finally in 2008 the Medicaid computer system upgrade is producing verifiable data and accurate reports. Attempts are being made to get these same reports run for 2006 and 2007. Until that time, 2008's accurate and final data are being used as a place-holder for those years.

Source of data: OMPP (Medicaid)

Notes - 2007
Finally in 2008 the Medicaid computer system upgrade is producing verifiable data and accurate reports. Attempts are being made to get these same reports run for 2006 and 2007. Until that time, 2008's accurate and final data are being used as a place-holder for those years.

Source of data: OMPP (Medicaid)

Notes - 2006
Finally in 2008 the Medicaid computer system upgrade is producing verifiable data and accurate reports. Attempts are being made to get these same reports run for 2006 and 2007. Until that time, 2008's accurate and final data are being used as a place-holder for those years.

Source of data: OMPP (Medicaid)

Narrative:
/2010/ Notes - 2008

The figure for 2008 should be provisional.

Notes - 2007
OMPP continues to investigate and will by mid to late August have a result for us in many areas which should allow us to determine which figures are outliers. Figures agreed to carry forward provisionally. //2010//
Notes - 2006
OMPP's new computer system has resulted in base year data that has been consistantly very low. 2006 indicator is provisional and represents further clarification received from OMPP without the acutal data being supplied by OMPP at this point. Unless OMPP's 2004 and 2005 figures were significantly in error, the provisional figure provided is an outlier. This will be flagged as being necessary to revisit when new data from OMPP is received. It may at that time need to be lowered. An estimate based on trend and base year would be 13.1 for 2006, which is what the figure is expected by data analysis to eventually be verified as being. However, it must be stressed that there is a great deal of fluctuation in figures of this nature as they are very low.

Notes - 2005
OMPP's new computer system had some necessary corrections which have now been made. 2003/2004 data will be changed by OMPP.

SFY 2005 data should be considered as base line and is the most accurate data available.

Notes - 2004
OMPP's new computer system is giving ISDH more accurate data than in prior years. 2004 figures should be used as baseline figures.

Source of data: Indiana Medicaid

Notes - 2003
Source of Numerator & Denominator: Office of Medicaid Policy & Planning. Figures for 2003 are being checked for accuracy by OMPP. Figure reported was incorrect due to computer error at OMPP. Actual figures for 2003 to be supplied by Medicaid before end of FY04.

Narrative:
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

In Indiana, there were 618 SCHIP enrollees whose age was less than one year at the end of the fiscal year. There were a total of 1,531 unduplicated SCHIP enrollees during the fiscal year who had at least one initial or periodic screen. From this data, it is not possible to determine the total number of unduplicated SCHIP infants <1 year of age who had at least one periodic screen, as the figure available contains duplicates.

Additionally, this information was only provided by Medicaid in estimate form prior to the installation of Medicaid's new computer system. Medicaid reported making corrections to their new computer system. Thus, 2005 data rather than 2004 data will be used as baseline data.

This measure has been subject to high variability in the past due to small numbers. SCHIP and Medicaid enrollment appears to have an inverse relationship. All of our funded MCH Projects are encouraged to become Medicaid/SCHIP enrollment centers to facilitate easy enrollment for

eligible family members.

/2009/ As of 2007, OMPP is still reporting fluctuating indicators provided by their upgraded computer system. It is hoped that when the actual figures from OMPP come in for 2006-2007 they will be more in line with the expected base year figures. However, as has been previously noted, there is a high variability in figures of this nature due to small numbers. This has continued to be the case. //2009//

/2010/ Problems and methods listed in 2009 continued. It is our belief that by late August OMPP will be able to finally provide us with verified figures. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	72.3	71.1	69.4	69.4	70.9
Numerator	62991	61767	61027		
Denominator	87124	86887	87936		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data not available. Projection made based on prior years' data.

Source of data will be ISDH ERC.

Notes - 2007
2007 data not yet available

Figure projected to be maintained at current level.

Source of Data will be ISDH ERC.

Notes - 2006
Source of data: ISDH ERC. Numerator calculated.

Narrative:
/2010/As Data from 2007 continues to remain unavailable until late August, estimate continued. //2010//

Notes - 2007
Data unavailable; estimate calculated based on trend analysis.

Notes - 2006

Numerator is calculated from the denominator and the percentage.

Source of data: ISDH ERC

Notes - 2005
Numerator is calculated from the denominator and the percentage.

Source of data: ISDH ERC

Notes - 2003
Numerator is calculated from the denominator and the percentage.

Source of data: ISDH ERC

Narrative:
The percent of women (15-44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Early and continuous prenatal care is promoted through the Indiana Perinatal Network "Baby First Right From the Start" Media Campaign, which promotes early prenatal care through billboards, free consumer videos, and print materials, the State Prenatal Care Coordination program which promotes early and continuous prenatal care utilization through outreach, education, and case management, and the MCH Free Pregnancy Test Programs which provides free tests to county agencies throughout the state.

In return for free pregnancy tests, agencies agree to assist all women with a positive pregnancy test into early prenatal care. There has been an increase in the use of community health workers and Baby First advocates providing outreach to pregnant women in targeted high-risk areas of the state with special project funding during FY 2005.

In 2004, 72.3% of all women in Indiana had adequate or adequate plus prenatal visits according to the Kotelchuck Index. The rate and the denominator for this figure are provided annually by the ISDH Epidemiology Resource Center; the numerator is then calculated. The OMPP has made the percent of women entering prenatal care in the first trimester a State Medicaid performance measure for State Medicaid MCOs.

/2009/ In 2006, 69.4% of all women in Indiana had adequate or adequate plus prenatal visits according to the Kotelchuck Index. The rate and the denominator for this figure are provided annually by the ISDH Epidemiology Resource Center; the numerator is then calculated. The OMPP has made the percent of women entering prenatal care in the first trimester a State Medicaid performance measure for State Medicaid MCOs. The small decline in percentage is due to fluctuation over time; the rate has 3.5% over the past several years, never in a straight line projection. While this is the lowest in a 4-year period, it has been the case that there has been a rebound after each lower percentage; that is hoped for in 2007 as well. //2009//

/2010/ Methods of measurement listed in 2009 update were continued.//2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Indicator	85.0	89.7	89.1	89.9	91.5
Numerator	417252	442210	587109	602779	622030
Denominator	490996	492835	659227	670468	679769
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Finally received actual data from OMPP for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Notes - 2007
Finally received actual data from OMPP for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Notes - 2006
Finally received actual data from OMPP for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Narrative:
Notes - 2008
With continued effort on the parts of both Medicaid and ISDH, new agreements have been reached in data sharing. OMPP was able to provide actual figures for this HSCI for 2007 and 2008

Notes - 2007
With continued effort on the parts of both Medicaid and ISDH, new agreements have been reached in data sharing. OMPP was able to provide actual figures for this HSCI for 2007 and 2008

Notes - 2006
No information was available from OMPP for this HSCI from their revised computer system for this time period. There will be, presumably, a patch to once again allow OMPP to provide th is information as they had int he past. For 2006-2007, indicators have been estimated based on trend analysis and approved by OMPP as reasonable projections.

Notes - 2005
Source of numerator OMPP
Denominator is calculated via trend analysis of previous OMPP data.

Notes - 2004
In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transitional period. Numerator available for 2004. Denominator for FY2004 provided by Medicaid as an estimate of number who meet eligibility

requirements as of end of FY2004.

Source of data: IOMPP

Notes - 2003
In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transition period between computer systems.

Source of data: IOMPP

Narrative:
Percent of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program.

This percentage increased from 85% to 89.7% based on information from Medicaid's new computer program.

/2009/ In 2006 the OMPP computer system which had been able to give us the information for this HSCI was unable to provide this to us. The problem is being worked on at OMPP and hopefully they will be able to give us the accurate data they have given us in the past, at which point we will keep it on hand for entry into next year's Title V Block Grant Application. For now, indicators for 2006 and 2007 were calculated based on trend analysis and submitted to OMPP who approved them as reasonable projections. //2009//

/2010/ As indicated might be possible, work proceeded between OMPP and ISDH to allow actual reporting figures for FY2007 and FY2008 as of this year.//2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	47.1	47.7	51.7	55.3	57.8
Numerator	70321	73219	68790	75577	79205
Denominator	149170	153452	133058	136558	137037
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Finally received actual data from OMPP for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Notes - 2007

Finally received actual data from OMPP for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Notes - 2006
Finally received actual data from OMPP for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Narrative:
Notes - 2008
With continued effort on the parts of both Medicaid and ISDH, new agreements have been reached in data sharing. OMPP was able to provide actual figures for this HSCI for 2007 and 2008

Notes - 2007
With continued effort on the parts of both Medicaid and ISDH, new agreements have been reached in data sharing. OMPP was able to provide actual figures for this HSCI for 2007 and 2008

Increase from 47.7 to 55.1. Source of data: OMPP

Notes - 2005
Indiana Medicaid has made some corrections to its new computer system which is providing more accurate data than in the past. 2005 rather than 2004 data should be used as baseline.

Notes - 2004
Indiana Medicaid has installed a new computer system which is providing more accurate data than in the past. However, Medicaid is still making some system corrections. 2005 should be used as baseline data.

Source of data: OMPP

Notes - 2003
Source of Numerator & Denominator: Office of Medicaid Policy & Planning.

Narrative:
The State slashed Medicaid dental reimbursements in 1994, which led to a mass exodus of dentists from the Medicaid program, and a decrease in dental health services to Medicaid eligible children. Reforms in Indiana's Medicaid Dental Program in 2001 led to an increase in the number of dentists providing dental health services to Medicaid enrollees.

Dental initiatives undertaken to promote utilization of dental services include Hoosier Healthwise educational brochures, referrals and advocacy from the MCSHC Indiana Family Helpline, MCSHC funding of the SEAL Mobile Unit to travel throughout the state and provide sealants to third grade students in school, requiring funded child health projects to report on the number of enrolled children receiving dental sealants, MCSHC funding of two dental health clinics within local health departments, and requirement of state funded community health centers to provide dental health.

Medicaid's new computer system has undergone some revisions in 2005; 2004's figure has been corrected following information received from those revisions. At 47.1% it still represents an

increase over 2003's 46.1% and is now a reasonable and correct reported rate. The rate continued to increase in 2005 to 47.7%.

/2009/ Medicaid continues to provide accurate figures which show a definite trend toward improvement in this area. For 2006 the rate went from 47.7 to 55.1, the highest increase in the past several years. Based on this upward trend, a projection has been made for 2007 to continue the positive direction of the program. There is also, finally, after the serious decrease in reimbursement rates for years, the possibility of increasing Medicaid dental reimbursement, which could happen as early as the current year. //2009//

/2010/ As indicated might be possible, work proceeded between OMPP and ISDH to allow actual reporting figures for FY2007 and FY2008 as of this year.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.4	2.0	2	2	2
Numerator	1662	401			
Denominator	19823	19823			
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Note: Both the 2007 and 2008 figures are expected to be available at the same time (i.e., end of August, 2009). Projected figure used since then. With numbers so low, fluctuation is possible, but unlikely to have a large impact in the indicators now that accurate data (from 2005) has eliminated the duplicates from 2004 and earlier. Source of denominator will be SSA/SSI web page when it is updated by the Feds shortly. Source of numerator will be ISDH CSHCS program, available by end of August.

Notes - 2007

Note: Both the 2007 and 2008 figures are expected to be available at the same time (i.e., end of August, 2009). Projected figure used since then. With numbers so low, fluctuation is possible, but unlikely to have a large impact in the indicators now that accurate data (from 2005) has eliminated the duplicates from 2004 and earlier. Source of denominator will be SSA/SSI web page when it is updated by the Feds shortly. Source of numerator will be ISDH CSHCS program, available by end of August.

Notes - 2006

Source of data: ISDH CSHCS. Federal SSA/SSI page not updated to include needed figures to make this more than an estimate.

Narrative:

Notes - 2008
With no update from SSA, the figures represented are so small that it is projected when that information becomes available it will remain the same (2%). However, with such small figures involved, it is possible for there to be considerable fluctuation in this indicator.

Note: ISDH will be able to provide the numerator for this measure very soon; the demonimator can then be calculated from the steady rate and confirmed as reasonable with the ISDH Epidemiology section.

Notes - 2007
Still no update from SSA. Again, the figures represented are so small that it is projected when that information becomes available it will remain the same (2%). However, with such small figures involved, it is possible for there to be considerable fluctuation in this indicator.

Notes - 2006
SSA no longer updates its website as they had begun doing; thus the figures cannot be accurately obtained for this measure using that method. The projection is that the figure will remain the same as the last accurate information from SSA and due to the small size of the sample involved.

Notes - 2005
We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated. Efforts are underway to deterimine a means to break out the appropriate age-range to ensure a direct comparison.

The CSHCS program provided the numerator for 2005, representing a 75% drop in number of children receiving rehabilitative services. This has been attributed by CSHCS to previous years' significant backlog of cases processed being virtually eliminated over the past two years after having been maintained at an overinflated level in years past. However, the extrememly low number may be an abberation and thus is only preliminarily a baseline.

Source of data: SSI, CSHCS program.

Notes - 2004
We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

FY 2004 will thus be used as baseline data.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated.

Numerator is defined as CSHCS clients in FY 2004 whose service was Therapy or outpatient and who had a revenue code of 420 through 449 on a claim and whose age was less than 16 years.

To give an accurate comparative figure, the same numerator but for children age less than 18 years is 1787, so the percentage comparing under 18's in both the numerator and denominator would be 9%.

Source of data: SSI, CSHCS program.

Notes - 2003
Source of denominator: Estimate provided by Social Security Administration.

Source of numerator: Provisional data, CSHCN Program.

Due to changes in both SSA's and CSHCN's databases, the figures as provided will be maintained for another year to better ensure accuracy.

Provisional FY2003 indicator is a projection based on multi-year data.

Narrative:
Indiana CSHCN Program provides rehabilitation services to children under the age of 16 receiving benefits under the Special Supplemental Insurance (SSI) Program to the extent medical assistance for such services are not provided through Medicaid. The CSHCS office provides Care Coordination, Eligibility, Prior Authorization, Claims Processing, Provider Relations, & Travel Reimbursement support services for providers and participants or their families.

Until 2005, a significant backlog in case processing inflated the numerator reported by the CSHCS program, & also thus artificially inflated the percentage. This backlog has been virtually eliminated, bringing the number of children and the percentage much lower. At the same time, SSA has begun providing some data through their web site, although it has not been updated for 2005.

Therefore, while 2004 shows a marked reduction in percentage over 2003, that figure is being observed as to potentially being baseline. CSHCS is continuing to check into the computer report for the numerator, which represents a 75% reduction over 2004, but this is the best figure they can provide at this time. It is provisional and is expected to change, and is expected to bring the percentage in line with 2004's baseline data. Per SSA, their web site data should be updated for 2005 as well, hopefully by the end of the year.

/2009/ Unfortunately, SSA no longer updates this section of their website and has not since 2005. However, after contact with SSA it is believed that they will be able to provide that information once again in accurate form beginning possibly next year. While with such small figures, there is a possibility for significant fluctuation, it is projected that the general low figure will remain consistant. //2009//

/2010/ With no SSA update, figures are so small it is projected when that information becomes available it will remain the same (2%). ISDH in August will provide the numerator & calculate denominator.//2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Percent of low birth weight (< 2,500 grams)	2008	other	9.5	7.4	8.1

Notes - 2010
Use of 2006 figures from last year's grant application necessitated as data for 2007 and 2008 not yet available.

Source of data will be ISDH - ERC and OMPP (Medicaid)

Note: Medicaid is currently researching to provide these figures for 2007 and 2008.

Narrative:
/2010/ Notes - 2008
Estimates continue to be used until later this year when FY 2007 data from both Medicaid and the Electronic Birth Certificates will be available. //2010//

Notes - 2007
For HSCI 05 a breakdown between Medicaid and Non-Medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

/2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

/2010/ Precise figures for comparisons should be available by late August from both Medicaid and Non-Medicaid sources.//2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all					

MCH populations in the State					
Infant deaths per 1,000 live births	2008	other	8	7	7.4

Notes - 2010
Use of 2006 figures from last year's grant application necessitated as data for 2007 and 2008 not yet available.

Source of data will be ISDH - ERC and OMPP (Medicaid)

Note: Medicaid is currently researching to provide these figures for 2007 and 2008.

Narrative:
/2010/ Notes - 2008
Estimates continue to be used until later this year when FY 2007 data from both Medicaid and the Electronic Birth Certificates will be available. //2010//

Notes - 2007
For HSCI 05 a breakdown between medicaid and non-medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January, 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

/2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

/2010/ Precise figures for comparisons should be available by late August from both Medicaid and Non-Medicaid sources.//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05	YEAR	DATA SOURCE	POPULATION

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	other	73.2	89.9	80.6

Notes - 2010
Use of 2006 figures from last year's grant application necessitated as data for 2007 and 2008 not yet available.

Source of data will be ISDH - ERC and OMPP (Medicaid)

Note: Medicaid is currently researching to provide these figures for 2007 and 2008.

Narrative:
/2010/ Notes - 2008
Estimates continue to be used until later this year when FY 2007 data from both Medicaid and the Electronic Birth Certificates will be available. //2010//

Notes - 2007
For HSCI 05 a breakdown between medicaid and non-medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January, 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

/2010/ Precise figures for comparisons should be available by late August from both Medicaid and Non-Medicaid sources.//2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	69.9	74.5	71.3

Notes - 2010
Use of 2006 figures from last year's grant application necessitated as data for 2007 and 2008 not yet available.

Source of data will be ISDH - ERC and OMPP (Medicaid)

Note: Medicaid is currently researching to provide these figures for 2007 and 2008.

Narrative:
/2010/ Notes - 2008
Estimates continue to be used until later this year when FY 2007 data from both Medicaid and the Electronic Birth Certificates will be available. //2010//

Notes - 2007
For HSCI 05 a breakdown between Medicaid and Non-Medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:
Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

/2010/ Precise figures for comparisons should be available by late August from both Medicaid and Non-Medicaid sources.//2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
Narrative:
The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana. Indiana's Medicaid program covers pregnant women and children ages one and under, with family incomes up to 150 percent of poverty. Infants of mothers on Medicaid during the pregnancy are automatically eligible for Medicaid at time of birth.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program.

Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

/2009/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to uninsured infants age 0 to 1 with family incomes up to 150 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured infants age 0 to 1 with family incomes between 150 percent and 200 percent of poverty are also covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistant. //2009//

/2010/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to uninsured infants age 0 to 1 with family incomes up to 150 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured infants age 0 to 1 with family incomes between 150 percent

and 200 percent of poverty are also covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistant. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	200

Narrative:
Narrative:
The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program. Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

/2009/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to uninsured children below the age of 21 with family incomes up to 133 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured children below the age of 21 with family incomes between 133 percent and 200 percent of poverty are covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistant. //2009//

/2010/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to uninsured children below the age of 21 with family incomes up to 133 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured children below the age of 21 with family incomes between 133 percent and 200 percent of poverty are covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistant. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	150

Narrative:
Notes - 2008
Pregnant women younger than 19 years of age are covered through SCHIP up to 200% of poverty level.

Notes - 2007
Pregnant women younger than 19 years of age are covered through SCHIP up to 200% of poverty level.

Narrative:
The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana. Indiana's Medicaid program covers pregnant women and children ages one and under, with family incomes up to 150 percent of poverty. Infants of mothers on Medicaid during the pregnancy are automatically eligible for Medicaid at time of birth.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program. Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

/2009/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to pregnant women with family incomes up to 150 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured pregnant women with family incomes between 150 percent and 200 percent of poverty are also covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistant. //2009//

/2010/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to pregnant women with family incomes up to 150 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured pregnant women below age 19 with family incomes between 150 percent and 200 percent of poverty are also covered. Recipients in this category are

required to pay a small monthly premium for coverage. This also has remained consistant. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2010

Narrative:
Notes - 2008
ISDH has improved its linkages and ability to directly access data in some cases.

Notes - 2007

The reason for the "No" in Direct access, as explained during our review, is due to the interpretation of the word "Direct" which, being capitalized, we took to mean specifically direct access the the original database, not mirrored, extracted, or copied versions of the database. In almost every case we have access to a version of the database in question. At the same time, in almost every case this is not what we believe was meant by "Direct access to the electronic database." We will discuss and change this next year if it is determined that "Direct" access can encompass more than the limited perspective we interpret it as meaning.

Narrative:
Indiana continues to work on linkages as specified in the following seven areas: annual linkage of infant birth and infant death certificates, annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files, annual linkage of birth certificates and WIC eligibility files, annual linkage of birth certificates and newborn screening files, a hospital discharge survey for at least 90% of in-State discharges, an annual birth defects surveillance system, and a survey of recent mothers at least every two years similar to the Prenatal Risk Assessment Monitoring Surveillance (PRAMS) survey.

The State Systems Development Initiative (SSDI) grant provides for oversight of the Data Integration and linkage projects through the Data Integration Steering Committee (DISC), the main output being the Operational Data Store (ODS). The ODS is the agency's main linkage mechanism. Progress has been made to such an extent that Indiana can now report successful linkage at least some of the time in all seven areas. MCSHC now has the ability to obtain data for program planning or policy purposes in a timely manner for all seven areas, and for birth certificate/death certificate information and the annual birth defects surveillance system MCSHC has that ability all of the time. Access to the electronic databases for analysis has also been achieved with regard to the Newborn Screening link, the birth defects surveillance system link, and the survey of recent mothers (PRAMS like survey). The plan is to continue work on the ODS including both input links and output via specific Data Marts in 2006.

The attached document for 09a is the narrative for Indiana Health System Capacity Indicator 09c, a new measure dealing with obesity.

/2009/ The reason for the "No" in Direct access, as explained during our review, is due to the interpretation of the word "Direct" which, being capitalized, we took to mean specifically direct access the the original database, not mirrored, extracted, or copied versions of the database. In almost every case we have access to a version of the database in question. At the same time, in almost every case this is not what we believe was meant by "Direct access to the electronic database." We will discuss and change this next year if it is determined that "Direct" access can encompass more than the limited perspective we interpret it as meaning. //2009//

/2010/ Due to work on the IDS and the new linkages therein, ISDH has improved its linkages and ability to directly access some Vital Records data (e.g., Electronic Birth Certificate data), Newborn Screening, and IBDPR data and is working on being able to directly access other data as part of its ongoing data integration/linkage project.//2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
Notes - 2008
The YRBS is completed every other year; notes from 2007 also apply in 2008.

Notes - 2007

Narrative:
Indiana high-school students are marginally more likely than their national counterparts to smoke cigarettes, according to the findings of the 2003 Indiana Youth Risk Behavior Survey conducted by the Indiana State Department of Health, MCSHC. Forty-eight high schools in the state and 1,674 students in grades 9 through 12 participated in the survey, which is part of a national study initiated by the Centers for Disease Control and Prevention to monitor student's health risks and behaviors.

2003 was the first time enough high schools in the state responded to the survey to allow the data collected to be weighted, that is, to be generalized for all Indiana high-school students. The Indiana Youth Risk Behavior Survey has been completed for 2005 with enough completed surveys to produce a weighted sample. Fewer Indiana teens are smoking.

The 2004 Indiana Youth Tobacco Survey (IYTS) shows that 21 percent of Hoosiers in grades 9-12 are smokers compared to 32 percent in 2000. This represents a 32 percent decline in smoking prevalence over the four-year period bringing Indiana's high school smoking rate below the national average. The Indiana Youth Tobacco Survey was conducted from November 2004 to January 2005 surveying more than 5,400 Indiana youth in grades 6-12 at 92 schools statewide. The survey included an over sample of African American and Hispanic youth.

Indiana Tobacco Prevention and Cessation (ITPC) programs adapted the Youth Tobacco Survey, developed by the Centers for Disease Control and Prevention, by adding questions designed for Indiana to serve as a surveillance measure for statewide tobacco use prevalence among youth. The full 2004 Indiana Youth Tobacco Survey Report is available at www.itpc.in.gov.

/2009/ 2005 YRBS Information: 53 High Schools, 1528 students grades 9-12 surveyed. //2009//

//2010// Re: Indiana Youth Tobacco Survey Report. Updated data from the most recent IYTS will be added in August. Re: YRBS: The YRBS is completed every other year; notes from 2007 also apply in 2008. The 2009 YRBS will be administered by ISDH in Fall 2009 with results reported in next year's application.//2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to: promote integration of public health and health care policy; strengthen partnerships with local health departments; collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities; support locally-based responsibility for the health of the community. The ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, ISDH Maternal and Children's Special Health Care Services (MCSHC) continues to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as state initiatives, based on the latest needs assessment. The needs assessment results focused on the following health status indicators: Asthma Hospital Discharges, Medicaid/CHIP Screening, Prenatal Care Adequacy, Low/Very Low Birthweight, MCSHC Access to Data Sources, Fatal/Non-Fatal Injuries, Chlamydia Rates, Dental Screening, and Adolescent Tobacco Use.

The needs assessment results have dictated the focus of the State Priorities listed in the following section, "B. State Priorities". Program and resource allocation issues are determined using the State Priorities for guidance. Utilizing the MCH "pyramid", program and resource funding has been carefully allocated to cover not only the State Priorities but also to cover all four of the "pyramid levels".

Direct Health Care is being evaluated with performance measures (PM) for Newborn Screening, CSHCS Family Participation, and Asthma Hospitalization. Enabling Services PM include the CSHCS Medical/Health Home and decreasing tobacco use in prenatal smokers. Population-based PM address CSHCS Insurance, CSHCS Community Systems, CSHCS Transition Issues, Immunization Rates, Teen Birth Rates, Dental Sealants, Child Motor Vehicle Accidents, and Lead Screening. Infrastructure Building PM include Breastfeeding Improvements, Newborn Hearing Screening, Child Health Insurance, Medicaid Usage, Very Low Birth Weight, Teen Suicide, High Risk Deliveries, Prenatal Care, Data Integration, Prenatal Care for Black Women, Birth Spacing, and Overweight Rates among High School Students. State and National Performance Measures have been established and hold ISDH MCSHC accountable for the success (or failure) of each of these initiatives.

Outcome Measure data for Infant Mortality, Black/White Infant Mortality Disparity, Neonatal Mortality, Postneonatal Mortality, Perinatal Mortality, and the Child Death Rate are also monitored and reported annually.

Specifically, within the "pyramid" level of Direct Medical Services, ISDH MCSHC funds programs to provide genetics services, immunizations, dental sealants, sickle cell prophylactic medicine, lead poisoning prevention, direct medical care for pregnant women, infants, children, adolescents, family planning, STD screens, free pregnancy screens, as well as speciality medical services and primary care for CSHCN. Funded Enabling Services programs provide genetics services education, prenatal and family care coordination, newborn screening and referral, sickle cell management, prenatal substance use prevention program (PSUPP), Indiana Child Care Health Consultation Program (ICCHCP) and coordination with Medicaid and WIC in addition to many other programs.
Population- Based Services that are provided by ISDH MCSHC or funded by MCSHC include the

Indiana Family Helpline (IFHL), the Early Childhood Comprehensive Systems (ECCS) program, the Indiana Joint Asthma Coalition (InJAC), the adolescent pregnancy prevention initiative, sudden infant death prevention, dental fluoridation efforts, and fetal infant mortality review. ISDH Infrastructure Building Services include efforts such as the Indiana Perinatal Network; the MCH, NBS and PSUPP data systems; the integration of data systems to facilitate the Indiana Birth Defects and Problems Registry (IBDPR), the Genomics in Public Health and Newborn Screening education efforts and other data analysis efforts for planning and reporting; policy and standards development; planning, evaluation, and monitoring; and quality assurance to MCSHC grantees.

Progress toward the achievement of our National and State performance goals is reported in Sections C and D, following. ISDH MCSHC continues to build on previous year's successes. This year's Annual Report reflects that for 2004, ISDH MCHSC met eight of the thirteen National performance measures for which FY 2004 data is available, and six of the seven previous State-Negotiated performance measures have been met. Progress could not be reported on the five performance measures that are reported through the CSHCN survey, as current data is not available. Of the five national performance measures and the state-negotiated performance measure that were not actually met, most were close.

MCSHC is proposing a new set of State Negotiated Performance Measures (SP) based on the results of the needs assessment. Several of the new SP are identical to the previous SP, only the number has been changed. Others are similar in the need addressed, but the measure has been changed to keep up with MCSHC progress in addressing that need. There are three entirely new proposed SP and some of the previous SP are being discontinued. These are enumerated in Sections B and D./2007/Final FY 2005 activities for the SP that are being discontinued are in section D, at the beginning of related (for the most part) new SP. In 2006, ISDH MCSHC met or exceeded 9 performance measures, did not meet but came close to meeting 8 performance measures and recorded progress on another 9 performance measures that were in transition.//2007//
/2008/ Finally in FY2006, ISDH MCSHC met or exceeded 14 performance measures, did not meet but came close to meeting 9 performance measures and recorded progress on another 3 performance measures.//2008// ***/2010/ With final data for 2006 complete and provisional data for 2007 available for many performance measures and outcome measures, it was determined that ISDH MCSHC met or exceeded 15 performance measures, did not meet but came close to meeting 9 performance measures, and recorded significant progress on 3 other measures and some progress on an additional measure.//2010//***

B. State Priorities

Indiana experiences high rates of low birthweight, infant mortality, and inadequate prenatal care with greater disparity among minority populations. Childhood immunizations, while significantly improving, are still below HP2010 targets and environmental hazards, such as lead and second hand smoke, threaten the health of tens of thousands of children and adults.

Risky behaviors among adolescents lead to teen pregnancy and childbearing, and high rates of tobacco use. Obesity among children and adults contributes to higher incidences of chronic diseases like diabetes and cardiovascular diseases that contribute to escalating health care costs.

A high priority must be given to expanding the availability of care for isolated rural residents and underserved urban and suburban persons and to assisting the MCH populations' access to needed services, including the continued need to identify early and link children with special health care needs to appropriate services. At the same time, broad based education and outreach is needed to improve knowledge of healthy practices among the entire population.

The top priority needs identified in Indiana are:
1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality.

2. To reduce both qualitative and quantitative barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families.
3. To build and strengthen systems of family support, education and involvement to empower families to improve health behaviors.
4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects.
5. To decrease tobacco use in Indiana.
6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs.
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity.
8. To reduce obesity in Indiana.
9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana.
10. To improve racial and ethnic disparities in women' of childbearing age, mothers', and children's health outcomes.

ISDH MCSHC Now reports on 8 State Negotiated Performance Measures (SP):
SP 01 The number of data sets, including the NBS, UNHS, Lead, Indiana Birth Defects and Problems Registry, Immunizations, CSHCS, and First Step Data, that are completely integrated into the Indiana Child Health Data Set. (Similar to previous SP 09)
SP 02 The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old. (Previously SP 10)
SP 03 The percent of live births to mothers who smoke. (Previously SP 11)
SP 04 The percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate. (Previously SP 12)
SP 05 The percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter. (Similar to previous SP 14)
SP 06 The proportion of births occurring within 18 months of a previous birth. (New)
SP 07 The number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities so that appropriate responses can be implemented at the local level to lessen these differences. (New)
SP 08 The percentage of high school students who are overweight. (New)

The identified priority needs will be impacted by activities in the listed Performance Measures as follow:
Priority 1 is addressed in PM 01, PM 08, PM 15, PM 17 & PM 18 and SP 01, SP 03, SP 04, SP 06 & SP 07
Priority 2 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06, PM 07, PM 09, PM 13, PM 14 & PM 19 and SP 04 & SP 07
Priority 3 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06 & PM 11 and SP 04, SP 05, SP 06, SP 07 & SP 08
Priority 4 is addressed in PM 01, PM 12, PM 17 & PM 18 and SP 01, SP 02, SP 03 & SP 05
Priority 5 is addressed in SP 03
Priority 6 is addressed in SP 01
Priority 7 is addressed in PM 08, PM 10 & PM 16
Priority 8 is addressed in SP 08
Priority 9 is addressed in PM 08 & PM 16
Priority 10 is addressed in PM 01 - 18 and SP 01 - 05 (All of them)

NOTE: In 2007 the definitions for Federal PM 14 and 15 changed significantly. These two PM now address different priorities:

PM 14 -- Priorities 1, 2, 3, 6, 7, and 8

PM 15 -- Priorities 1, 2, 3, 4, 5, and 10

MCSHC grants approximately $7.5 million to fund more than 50 local and statewide projects that build infrastructure and provide population-based, enabling and direct services to meet these objectives. Additionally, beginning in FY 2005, MCSHC has provided approximately $1 million in one-time infrastructure grant funds to more than 30 local and statewide projects to conduct community needs assessment, operate pilot projects or otherwise address the priority needs and performance measures above.

/2007/Because of reductions in Title V allocations and increased costs, MCSHC is reducing grant funding from $8.5 million in FY 2006 to $6.5 million in FY 2007. This requires early termination of most of the one-time Special Projects initiated in FY 2005 and reductions of 6% to 11% for existing service providers. Special Projects being cut include obesity prevention and lead poisoning prevention. However, MCSHC has added obesity prevention performance measures to service provision requirements for most currently funded service providers and is also providing information about lead screening requirements and medical management recommendations for children ages 6 to 84 months to all currently funded service providers.

Additionally, MCSHC projects some cost savings for Family Planning provision by combining Title V and Title X Family Planning services. MCSHC will provide all Title V Family Planning services through a grant to the Indiana Family Health Council, the delegate for all Title X funding for Indiana.//2007///2008/ MCSHCS is working toward distributing the Title XX and TANF family planning funding in FY 2009//2008///2009/ Beginning of Title XX and TANF Family Planning funding will not begin until at least October 1, 2009 //2009///***2010/This consolidation of family planning funds should take place in 2010.//2010//***

Activities of MCSHC staff and grantees to meet these performance measures are discussed in sections C and D below.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99	99.2	100	100	100
Annual Indicator	100	100.0	100.0	100.0	100.0
Numerator		111	126	132	149
Denominator		111	126	132	149
Data Source					ISDH - NBS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	98

Notes - 2008
Beginning next year we will be reporting this measure with a slightly different interpretation than in the past. Rather than treating referrals as appropriate follow-up services received, we will be tracking percentage who receive services from those referrals. Thus the figure, while high, will no longer be 100% for this measure.

Objectives have been lowered to 98% in anticipation of the lower outcome expected. 2009 will be treated as baseline data.

Source of data: ISDH NBS Program

Notes - 2007
Provisional based on calculations now used (see 2006 note for details).

Notes - 2006
Note: All tests except for Sickle Cell TRAIT are included in the 2006 total.
Due to the new system in place for determining appropriate need for follow up, 100% of our confirmed positives will now always receive appropriate follow-up.

Source of data: ISDH NBS program.

a. Last Year's Accomplishments
FY 2008 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Status: Met - 100% Maintained

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

Newborns whose screens were invalid, abnormal, or positive received follow-up.

All infants with confirmed positive results were referred to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the CSHCS programs.

NBS continued to provide in-service training to Public Health Nurses, midwives, hospitals, and birthing centers.

NBS began to develop the NBS Data mart in the Operational Data Store to allow more efficient and effective tracking and follow-up of babies who received a positive heel-stick for certain conditions.

NBS added Cystic Fibrosis to the NBS panel on January 1, 2008

The NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NBS is continuing to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.	X			
2. NBS is continuing to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the Children's Special Health Care Services.	X			
3. NBS is continuing to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. An updated presentation for Public Health Nurses is near completion for implementation online.				X
4. NBS is continuing to develop the NBS Data mart in the Operational Data Store. This system will allow more efficient and effective tracking of all babies ensuring all receive a valid screen and appropriate follow-up.				X
5. The NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

NBS is continuing to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.

NBS is continuing to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the Children's Special Health Care Services (CSHCS) programs.

An updated in-service training presentation for Public Health Nurses is near completion for implementation online.

NBS is continuing to develop the NBS Data mart in the Operational Data Store. This system will allow more efficient and effective tracking of all babies ensuring all receive a valid screen and appropriate follow-up.

The NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

NBS will continue to follow-up on all invalid, abnormal, and positive test results until they are

complete and negative or the babies are receiving treatment.

NBS will continue to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the Children's Special Health Care Services (CSHCS) programs.

NBS will continue to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. An updated presentation for Public Health Nurses is near completion for implementation online.

NBS will begin pilot testing of the NBS (Heel stick) Data mart in the Operational Data Store. This system will allow more efficient and effective tracking of all babies ensuring all receive a valid screen and appropriate follow-up.

The NBS Director will continue to participate in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	63	63	63	64	60
Annual Indicator	61.1	61.1	61.1	59.3	59.3
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	61	61	62	62

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Application Program will not allow change in objectives for current or previous years.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percent of children with special health care needs ages 0 to 18, whose families partnered in decision-making at all levels, who were satisfied with the services they received, was determined based on the National Survey of Children with Special Health Care Needs (NS-CSHCN) data, for which FY 07 results are not yet available.

Status: 59.3 % per 2005/2006 CSHCN Chart book.

a. FY 2008 Accomplishments

Activities that impacted this performance objective included:

The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) was developed in February 2008, to create a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community --based and culturally competent.

The C.I.S.S. sub-committee titled "Family/Professional Partnerships"; whose focus is to enhance systems of care for CYSHCN that enables families to partner in decision-making at all levels and be satisfied with the services they receive, continued its work.

CSHCS updated their English and Spanish versions of the CSHCS Program Brochure and created program Fact Sheets for marketing use.

CSHCS finalized its review and update of the CSHCS Participants Manual and Transition Manual. Both manuals were reviewed by parents and the manuals were mailed to all participants.

CSHCS developed/tested a new CSHCS application for the program.

CSHCS mailed a Summer and Winter newsletter to all participants.

CSHCS updated the CSHCS Program website to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters. Links to other resources for families were created that allowed accessibility to resource information as needed by participants and their families.

CSHCS participated as an Exhibitor at 6 Conferences throughout the state for CYSHCN and provided training on the CSHCS program to local agencies that work with CYSHCN.

CSHCS continued its grant funding to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities. FY 2008 activities included the following:

1.Parent to parent contact through the telephone was available to families for questions related to health care coverage, education, early intervention, community resources, training and other issues. During FY 08 a total of 3,440 new families and professionals were served by ASK staff. In addition, 7,514 families and professionals were contacted though ASK's follow-up protocols

throughout the year.

2.ASK connected on a monthly basis with pediatric residents who are being trained at Indiana University. Residents were taught about community resources and the importance of sharing this information with families who they will be seeing in practice.

3.ASK offered trainings to families and professionals about special education and health care financing. Scholarships were available to families who could not afford to attend the trainings.

4.ASK produced a monthly e-newsletter that was sent out to more than 1,000 families and professionals each month. The e-newsletter contains information pertinent to both professionals and families.

5.ASK sent out CHSHCS program applications from its office during the grant cycle.

Medical Director worked with ISDH Disaster Preparedness to assure needs of CSHCN were included.

CSHCS participated in 9 statewide "Road Shows" with members of the Indiana State Transition Team where we presented information about the CSHCS program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) continued its monthly meetings to work on improving access to quality, comprehensive, coordinated community-based systems of services for CYSHCN.		X		
2. The C.I.S.S. Advisory Committee sub-committee titled “Family/Professional Partnerships”; whose focus was to enhance systems of care for CYSHCN that enabled families to partner in decision-making , and be satisfied with the services they receive.		X		
3. CSHCS produced and mailed a CSHCS Summer Newsletters to all participants.		X		
4. CSHCS continued to keep the CSHCS Program website updated to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters for families.		X		
5. CSHCS was not able to provide the updated CSHCS Program Brochures to all CSHCS providers, parent support agencies and other community-based systems that care/support CYSHCN due to budget restraints.		X		
6. CSHCS continued to provide Developmental Calendars, Transition Resources- including the CSHCS Transition Manual and Health Care financing options to all its participants.				X
7. CSHCS continued its grant funding to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing information, peer support & education & building partnerships with professionals.				X
8. CSHCS participated in statewide trainings, conferences and exhibitions to promote the CSHCS program.				X
9.				

10.				

b. Current Activities
b. FY 2009 Current Activities

The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) continued its monthly meetings to work on improving access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community --based and culturally competent.

The C.I.S.S. Advisory Committee sub-committee titled "Family/Professional Partnerships" worked to identify Indiana's strengths and needs around this topic, identified activities and made recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve community-based service systems around Family/Professional Partnerships. This information was used to apply for HRSA/MCHB State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs (CYSHCN) which was submitted March 2009 and Indiana was awarded a grant in May 2009.

CSHCS produced and mailed a CSHCS Summer Newsletters to all participants.

CSHCS continued its grant funding to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work on improving access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community --based and culturally competent. In May 2009, the CISS Advisory Committee received notification of awards for the Improving Systems of Services for CYSHCN grant . The CISS Advisory Committee will move forward with the focus activities outlined in the grant, Medical Home Learning Collaborative, Transition to Adult Healthcare and Work and building the capacity of the CISS Advisory Committee that will take on the responsibility of providing oversight to initiatives for CYSHCN and their families throughout the state.

The C.I.S.S. Advisory sub-committee "Family/Professional Partnerships" will have a key role in coordinating the improving systems of services grant project to achieve community-based service systems around Family/Professional Partnerships.

CSHCS will produce and mail a Summer and Winter CSHCS Newsletter to all participants and professionals involved with the program.

CSHCS will provide the updated CSHCS Program Brochures to all CSHCS providers, parent support agencies and other community-based systems that care/support CYSHCN.

CSHCS will continue to provide Developmental Calendars and Transition Resources including the CSHCS Transition Manual and Health Care financing options to all its participants.

CSHCS will continue to keep the CSHCS Program website updated to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters. Links to other resources for families were created that allowed accessibility to resource information as needed by participants and their families.

ASK will continue to receive grant funding from CSHCS at a reduced amount due to budget restraints. ASK will continue its work with families and professionals served through its staff and programs.

ASK will work with CSHCS to educate families and professionals about Medical Home.

ASK will participate with the Indiana State Department of Health on advisory committees to special projects, insuring that the family perspective is always present throughout the planning processes.

ASK will continue to send an e-newsletter and anticipates that readership will reach over 1200 during the coming year.

CSHCS will continue to participate in statewide conferences and exhibitions to promote the CSHCS program.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	56	56	56	56	55
Annual Indicator	55.7	55.7	55.7	54.6	54.6
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	56	56	57	57

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions

and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Application Program will not allow change in objectives for current or previous years.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percent of CSHCN in Indiana who have a "Medical Home will be 54.6 %.

Status: 54.6% per 2005-2006 NC-CSHN data. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this performance objective included:

ASK continued to provide on a monthly basis to pediatric residents who are being trained at Indiana University information about community resources and the importance of sharing this information with families who they will be seeing in practice.

ASK participated on the Community Integrated Service Systems (CISS) Advisory Committee and also had representation on three of the subcommittees of this project. Initial work was begun to develop surveys for medical professionals and for families about medical home.

MCSHC continued its work to select or develop a brochure for physicians about the medical home concept.

MCSHC convened The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) in February 2008, to create a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community--based and culturally competent.

The C.I.S.S. "Medical Home" sub-committee made recommendations to coordinate for Indiana the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the goal of coordinated, ongoing, comprehensive care within a Medical Home.

MCSHC began an In-house Care Coordination System in April 2008. The Care Coordinators linked the participants to a Primary Care Physician (PCP), provided the families with "Tools" to help them prepare for medical visits and educated CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. MCSHC will continue to distribute an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs.		X		
2. ASK will continue to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families they serve.				X
3. CSHCS will continue to facilitate the Community Integrated Systems of Services (C.I.S.S.) Advisory Committee and have ASK participate on the Medical Home subcommittee of this project to further the plan for spreading the medical home concept .				X
4. CSHCS worked with ASK to collect information from families about their understanding of a medical home. After the survey, ASK assisted the Integrated Community Services Program in identifying steps to take toward furthering the medical home concept.		X		
5. The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs.		X		
6. The C.I.S.S. sub-committee titled “Medical Home” made recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana.				X
7. MCSHC will continue to develop the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits.		X		
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

ASK will continue to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in practice.

CSHCS will continue to facilitate the Community Integrated Systems of Services (C.I.S.S.) Advisory Committee and have ASK participate on the Medical Home subcommittee of this project to further the plan for spreading the medical home concept more broadly in Indiana.

CSHCS worked with ASK to collect information from families about their understanding of a medical home. Following the survey, ASK assisted the Integrated Community Services Program in identifying steps to take toward furthering the medical home concept in Indiana.

The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

MCSHC will distribute an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs.

ASK will continue to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in practice.

CSHCS will continue to facilitate the Community Integrated Systems of Services (C.I.S.S.) advisory committee and have ASK participate on the Medical Home subcommittee of this project to further the plan for spreading the medical home concept more broadly in Indiana.

CSHCS will work with ASK to collect information from professionals about their understanding of a medical home. Following this survey, ASK will assist CSHCS in identifying steps to take toward furthering the medical home concept to professionals in Indiana.

The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community --based and culturally competent.

The C.I.S.S. sub-committee titled "Medical Home" will play a key role in development of the Medical Home Learning Collaborative as part of the Improving Systems of Services grant project.

MCSHC will continue to develop the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with "Tools" to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	65	65	67	67	62
Annual Indicator	63.3	63.3	63.3	61.8	61.8
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	62	63	63	64	64

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Application Program will not allow change in objectives for current or previous years.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
FY 2008 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be maintained at 67% in FY 2008.

Status: 61.8% in 2008

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

Actual figures, based upon information in the Agency Claims and Administrative Processing System (ACAPS), of participants in Indiana's CSHCS program who have either private or public health insurance is 90.95%. Of that total percentage, 48.88% of participants have some kind of private health insurance and 42.07% have Medicaid.

CSHCS tracked insurance utilization in ACAPS. This activity allowed for denial of claims for which other insurance coverage is available.

CSHCS monitored the activities and progress of the Health Insurance for Indiana Families Committee, a group of state leaders charged with developing no-or low-cost options to provider services for the uninsured.

CSHCS monitored the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of children and adults who benefit from federal and state health care coverage programs.

The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. As a part of this grant, ASK staff members spoke with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and helped families navigate through the complex systems.

ASK offered trainings to families and professionals that outline the various public health insurance programs. Follow-up with an ASK Parent Liaison helped families determine which of these programs will serve their children the best. ASK staff spoke with 2,416 families in Indiana about health insurance options.

ASK provided training to approximately 80 participants on Understanding Public Health Insurance Options.

CSHCS program sent all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.

Sunny Start (Indiana's ECCS initiative) created a series of 22 financial fact sheets to aid families with information on a variety of key financial resources including insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCS updated the ACAPS system to utilize insurance information for processing electronic pharmacy claims. (COB) processing of pharmacy claims has been accomplished and we are currently working on electronic COB processing for medical claims.		X		
2. CSHCS reviewed and followed-up on system reports that were created to identify coordination and benefit issues for electronic pharmacy claims.				X
3. CSHCS sent information to providers which clarified our reimbursement methodology as it relates to other insurance and the maximum allowable payment. A provider bulletin has been sent to providers.				X
4. CSHCS updated both the Provider and Participant Manual.		X		
5. The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families.				X
6. ASK offered trainings to families and professionals that outlined the various public health insurance programs. Follow-up with an ASK Parent Liaison can help families determine which of these programs will serve their children the best.				X
7. ASK serves as Indiana's Family to Family Health Information and Education Center (F2FHIC). As Indiana's F2FHIC, ASK has the opportunity to meet quarterly with stakeholders from the state, community and families.			X	
8. ASK currently has representation on the C.I.S.S. subcommittee addressing uninsured and underinsured children in our state.				X
9. ASK has revised its public health insurance training. The curriculum will be publicized and offered to both families and professionals with a "menu" of topics that the requesting party can select from to allow for the training to be customized.				X
10. CSHCS program continued to send all participants age 17		X		

years and up information on insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.				

b. Current Activities
b. FY 2009 Current Activities

CSHCS updated the ACAPS system to utilize insurance information for processing electronic pharmacy claims. Electronic Coordination of Benefits (COB) processing of pharmacy claims has been accomplished and we are currently working on electronic COB processing for medical claims.

CSHCS reviewed and followed-up on system reports that were created to identify coordination and benefit issues for electronic pharmacy claims.

CSHCS sent information to providers which clarified our reimbursement methodology as it relates to other insurance and the maximum allowable payment. A provider bulletin has been sent to providers.

CSHCS updated both the Provider and Participant Manual.

The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. As a part of this grant, ASK staff members speak with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and can help families navigate through these complex systems.

ASK offered trainings to families and professionals that outlined the various public health insurance programs. Follow-up with an ASK Parent Liaison can help families determine which of these programs will serve their children the best.

ASK serves as Indiana's Family to Family Health Information and Education Center (F2FHIC).

c. Plan for the Coming Year
c. FY 2010 Planned Activities

CSHCS will complete the electronic COB process for medical claims which will allow medical claims to be processed more quickly.

CSHCS will continue to review and follow-up on system reports that were created to identify coordination of benefit issues for electronic pharmacy claims.

ASK will continue to serve on the CISS subcommittee addressing uninsured and underinsured children and will work with the committee to develop a plan of action related to this topic.

The new ASK public health insurance training curriculum will be publicized and offered to both families and professionals in the coming year. The new curriculum will feature a "menu" of topics that the requesting party can select from so that the training can be customized.

CSHCS program will continue to send all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.

The (C.I.S.S.) sub-committee titled "Access to Adequate Health Insurance" will complete recommendations to coordinate the development, implementation and evaluation of a State

Integrated Community Services Plan to achieve the adequate health insurance.

The CSHCS program will continue as a "Registered Agency" with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	80	80	80	95
Annual Indicator	79.5	79.5	79.5	94.3	94.3
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	96	96	97	97

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Application Program will not allow change in objectives for current or previous years.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
FY 2008 Performance Objective: 80% of families with CSHCN age 0 to 18 will report the community-based service systems are organized so they can use them easily.

Status: 94.3 % per the 2005-2006 NS-CSHCN. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. ASK assists families navigating the complex systems of community resources in the following ways:

ASK has an online resource directory that highlights local, statewide, and national resources specifically for children with special health care needs. The directory is searchable by topic area, county and by keyword and can be accessed at any time through the internet. There were over 50,000 hits on this site.

ASK works one on one with families who need assistance navigating through the complex system of community resources. This one on one assistance comes from the ASK Parent Liaison staff who guide each individual to the resources that are appropriate for their families. There were over 10,000 families served. (These were new families and follow ups with previously identified families.)

With funding assistance from the Indiana State Department of Health, ASK developed community resource pads and a community resource poster that has been distributed to health care settings, and through various information fairs throughout the state. Key community resources were selected for listing on these materials and they were made "user-friendly" so that they could easily be utilized.

MCSHC maintained an 800 Family Help Line with V/TDD capabilities and bilingual support and referred families to community-based services.

CSHCS provided community based-training to First Steps providers and The Division of Family Resources (DFR) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.

CSHCS continued to reimburse families for in-state and out-of-state transportation for CSHCS participants to medical facilities for services.

CSHCS provided outreach to Neonatal Intensive Care Units (NICU), and maintains and provides lists of primary care physicians participating in the CSHCS program.

To facilitate receipt of CSHCS applications, CSHCS promoted Single Points of Entry (SPOE) early intervention sites, and used local Offices of Family Resources to take CSHCS applications.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCSHC began an In-house Care Coordination System in April 2008. The Care Coordinators assess the participants and their families needs and make appropriate referrals, and link the participants to a Primary Care Physician (PCP).	X			
2. CSHCS continued its funding and collaborating with About Special Kids (ASK) and its statewide network of family-to-family peer support.				X
3. ASK has continued to add resources and to update resources			X	

in its directory and during this year, added a for profit component to the directory (previously, the directory only included nonprofit resources).				
4. ASK has helped over 12,000 families access appropriate community resources during this grant year.		X		
5. With funding assistance from the Indiana State Department of Health, ASK continues to update the Marion County community resource pads and also the statewide community resource poster that has been distributed to health care settings.				X
6. CSHCS continues to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.	X			
7. CSHCS provides outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.		X		
8. CSHCS promotes Single Points of Entry (SPOE) early intervention sites, and uses local Offices of Family Resources to take CSHCS applications.	X			
9. CSHCS continues using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.	X			
10. CSHCS will begin to evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to study how well they assist families in using community based services.		X		

b. Current Activities

b. FY 2009 Current Activities

MCSHC began an In-house Care Coordination System in April 2008. The Care Coordinators assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families with "Tools" to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

CSHCS continued its funding and collaborating with About Special Kids (ASK) and its statewide network of family-to-family peer support.

ASK has continued to add resources and to update resources in its directory and during this year, added a for profit component to the directory (previously, the directory only included nonprofit resources). In this section, for profit companies, who are specifically addressing the needs of children with special health care needs, are listed for a fee. A disclaimer is offered to families so that they know that the organization does not endorse any specific for profit entities.

ASK has helped over 12,000 families access appropriate community resources during this grant year.

With funding assistance from the Indiana State Department of Health, ASK continues to update the Marion County community resource pads and also the statewide community resource poster.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

MCSHC will continue to develop the In-house Care Coordination System. The Care Coordinators will continue to assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families with "Tools" to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

CSHCS will continue to fund and collaborate with About Special Kids (ASK) and its statewide network of family-to-family peer support.

ASK will continue to update existing resources in its online directory and will add new resources as they become available.

ASK will continue to serve families on a one on one basis and will continue to provide follow-up to these families to insure that they are accessing the appropriate resources.

ASK will continue to seek funding to update additional counties' community resource cards.

The C.I.S.S. sub-committee titled "Organization of Community Services for Easy Use By families" will continue its work and make recommendations to coordinate the development, implementation and evaluation of the State Integrated Community Services Plan as part of the Improving Systems of Services grant project.

MCSHC will maintain an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.

CSHCS will provide current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.

CSHCS will continue to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services although the reimbursement rate has been decreased due to more limited state funding.

CSHCS will provide outreach to Neonatal Intensive Care Units (NICU), and maintain and provide lists of primary care physicians participating in the CSHCS program.

CSHCS will continue to promote Single Points of Entry (SPOE) early intervention sites and local Offices of Family Resources to take CSHCS applications.

CSHCS will continue using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.

CSHCS will continue to publish a bi-yearly (Summer and Winter) newsletter which includes informative articles and any program updates that affect participants (i.e., policy changes, new mileage reimbursement rates, etc.).

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	6	6	6	41.5
Annual Indicator	5.8	5.8	5.8	41.1	41.1
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	41.5	42	42	42	43

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Application Program will not allow change in objectives for current or previous years.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
FY 2008 Performance Objective: 8% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life

Status: 41.1 % (2005-2006 NS-CSHCN).

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

Children's Special Health Care Services (CSHCS) continued to distribute the Transition Manual

to 100% of CSHCS participants ages 14 years and older. CSHCS distributed the Transition Manual at health and transitional fairs that it attended as an exhibitor.

CSHCS staff continued to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CYSHCN) to adult life.

CSHCS published a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems on numerous topics including Transition.

CSHCS and The Center for Youth and Adults with Conditions of Childhood (CYACC) Transition Clinic continued to develop transition assistance for clients and training for providers.

CSHCS worked with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.

The CYACC Transition Project worked with health care providers statewide on transitioning youth with special health care needs to adult care.

Materials and tools developed at the CYACC transition clinic continued to be distributed to other providers.

The CISS Advisory Committee established a Transition sub-committee whose focus was to evaluate Indiana's strengths and needs around transition and identify objectives and activities to improve the areas of identified need.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCS will continue to distribute the Transition Manual to 100% of CSHCS participants ages 14 years and older.		X		
2. CSHCS will continue to distribute the Transition Manual at health and transitional fairs that it attends as an exhibitor.		X		
3. CSHCS staff will continue to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.				X
4. CSHCS will continue to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.		X		
5. CSHCS and CYACC Transition Clinic will continue to develop transition assistance for clients and training for providers.				X
6. CSHCS will continue to work with interagency initiatives (Indiana’s State Transition Team, Department of Education 290 Group & CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.				X
7. The CYACC Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.				X
8. Materials and tools developed at the CYSHCN transition clinic will continue to be distributed to other providers.				X

9. The CISS Advisory Committees Transition sub-committee will continue its focus to evaluate Indiana's strengths and needs around transition and identify objectives and activities to improve the areas of identified need.				X
10.				

b. Current Activities

b. FY 2009 Current Activities

CSHCS distributes the Transition Manual to 100% of CSHCS participants ages 14 years and older.

CSHCS distributes the Transition Manual at health and transitional fairs that it attends as an exhibitor.

CSHCS staff to receives ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.

CSHCS publishs a semi-annual newsletter to CSHCN families and participants with listings for community resources and support systems.

CSHCS and CYACC Transition Clinic develop and distribute transition tools for clients and providers, as well as training for providers.

CSHCS works with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.

The CYACC Transition Project works with health care providers statewide on transitioning youth with special health care needs to adult care.

The CISS Advisory Committee Transition sub-committee and CYACC staff contributed to the development of the Improving Systems of Care for CYSHN grant application submitted in March 2009.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

CSHCS will continue to distribute the Transition Manual to 100% of the CSHCS participants ages 14 years and older.

CSHCS will continue to distribute the Transition Manual at health and transitional fairs that it attends as an exhibitor.

CSHCS staff will continue to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.

CSHCS will continue to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.

CSHCS and CYACC Transition Clinic will continue to develop transition assistance for clients and training for providers.

CSHCS will continue to work with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for

disabled individuals from school to work or youth to adult health services.

The CYACC Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.

Materials and tools developed at the CYSHCN transition clinic will continue to be distributed to other providers.

The CISS Advisory Committees Transition sub-committee works on improving systems for CYSHCN as they transition to adult healthcare, work and independence. As part of the Improving Systems of Care grant project a planned activity to accomplish this goal will be to contract with CYACC to develop and provide tools, resources and Educational Office Visits (EOV) to build partnerships with community physicians and/or their healthcare teams to assist in meeting the transition needs of CYSHCN in their practices.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	81	81	84	84
Annual Indicator	79.0	81	83.2	76.8	89.1
Numerator	200692				
Denominator	254041				
Data Source					ISDH - Imm. Pgm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	85	86	86	87

Notes - 2008
Figure provided without numerator or denominator.

Source of data: ISDH Immunization program.

Notes - 2007
This represents the low end of the 95% confidence level rather than the median and thus appears to be a drop when actually it is not. The original provisional figure of 84 has been corrected to match the final data provided by the IDH immunization program.

Source of data: ISDH Immunization program.

Notes - 2006

Source of data: ISDH Immunization Program.

Figure used is the lowest of the figures provided by the ISDH Immunization program for this group of immunizations and this age range. Individual numerator and denominator figures were not provided; however, we expect to receive those later in the year.

Objectives for 2007 and forward have been revised upwards due to FY2006 success.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percent of 19 to 35 month olds who have received the full schedule of age-appropriate immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae, and Hepatitis B (4:3:1:3:3) will increase to 84% in 2008.

Status: 2008 data show 89.1% of children 19-35 months of age had received the 4:3:1:3:3 immunization series.)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

The Immunization Program provided vaccines to Maternal and Child Health (MCH) sites enrolled in the Vaccines for Children (VFC) program.

The Immunization Program conducted VFC and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH worked with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.

MCH Health Systems Development staff attended the Indiana Immunization Coalition and participated in its activities.

The legislature increased cigarette tax by 44 cents per package, a portion of which was used to buy vaccines.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Immunization Program continues to provide vaccines to Maternal and Child Health (MCH) sites enrolled in the Vaccines for Children (VFC) program.	X			
2. The Immunization Program continues to conduct VFC and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.				X
3. MCH continues to work with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.				X
4. MCH Health Systems Development staff continues to attend the Indiana Immunization Coalition and participate in its activities.				X

5. MCH continues to work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
b. FY 2009 Current Activities

The Immunization Program provides vaccines to Maternal and Child Health (MCH) sites enrolled in the Vaccines for Children (VFC) program.

The Immunization Program conducts VFC and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH works with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.

MCH Health Systems Development staff attends the Indiana Immunization Coalition and participate in its activities.

MCH works with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

ISDH conducted a television media campaign with State Health Commissioner, Dr. Judith Monroe, urging families to have their children vaccinated.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

The Immunization Program will conduct Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled Maternal and Child Health (MCH) sites to assess implementation of VFC policies.

MCH will work with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.

MCH will coordinate with the Immunization Program to provide educational opportunities for WIC program staff due to WIC Staff needing to be trained on how to use CHIRP, how to determine current immunization status, and how to enter and read test results in CHIRP.

MCH Health Systems Development staff will attend the Indiana Immunization Coalition and participate in its activities.

MCH will work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	22	20	19.5	19	20.1
Annual Indicator	20.9	20.5	20.8	22.0	21.5
Numerator	2749	2757	2808	2954	
Denominator	131532	134457	134753	133975	
Data Source					ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	19.8	19.6	19.4	19.2

Notes - 2008
Figure projected from past data.

Source of past data: ISDH ERC

Notes - 2007
ERC provided updated provisional data for rate and numerator; denominator calculated from those figures

Source of data: ISDH ERC.

Notes - 2006
No data available for FY2006 at this time. We are in process of acquiring FY2006 data and hope to have that data later in the year.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 18.9 in FY 2008.

Status: The birth rate per 1,000 females for ages 15-17 was 21.5 for 2008.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

The state adolescent health coordinator (SAHC) submitted an application for receipt of federal Abstinence Education Grant Program funds to support Indiana RESPECT for fiscal years 2009-2013. The application was approved.

The SAHC provided training on program adaptation and a training on evaluation to Indiana RESPECT grantees. These trainings were conducted with a partner organization, Health Care

Education and Training, Inc. (HCET).

Due to state restrictions on marketing, the media campaign for Indiana RESPECT was not prominent the second half of FY08. However, Indiana RESPECT did continue to disseminate educational materials at community events such as Indiana Black Expo Minority Health Fair and Fiesta Indianapolis and do mailings of educational materials to those requesting such information.
.

The MCSHC Division funded five school-based clinics which were a source of prenatal care coordination and/or on-site referral for prenatal care coordination for any pregnant student who comes to the clinic, and for support for "at risk" youth. MCSHC continued its Free Pregnancy Test program to provide counseling and referrals to healthcare providers, or provide abstinence or family planning information to sexually active teens with negative pregnancy test.

The SAHC continued to facilitate the Indiana Coalition to Improve Adolescent Health. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.

The SAHC promoted the 2008 National Day to Prevent Teen Pregnancy. Materials regarding the National Day and Indiana RESPECT were sent out to all middle schools, high schools, private schools in Indiana; to current and past Indiana RESPECT grantees; and to school-based clinics throughout the state. A press release about the National Day was released by the Indiana State Department of Health.

The SAHC attended the Healthy Teen Network's Annual Conference in November 2007, including a pre-conference training on science-based approaches to prevent teen pregnancy. The SAHC attended the Association of Maternal and Children's Health Programs in March 2008. Several of the breakout sessions were specific to issues in adolescent health and included data and information on teen sexual behaviors and pregnancy.

The SAHC currently is a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy, STD's, and HIV among adolescents and translate this research into user-friendly materials to disseminate to the field.

The SAHC assisted with the administration of the 2007 Youth Risk Behavior Survey (YRBS) and prepared the fact sheet for adolescent sexual behaviors for the release of Indiana data in December 2007.

The SAHC was part of the planning committee for the first ISDH youth summit held in the state held in March 2008. The summit offered breakout sessions to students on healthy relationship and evaluating one's relationships.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The state adolescent health coordinator (SAHC) will submit all necessary documentation and paperwork to ensure continuation of federal Abstinence Education Block Grant funds through fiscal year 2013.				X
2. The SAHC will oversee the FY2010-2011 Indiana RESPECT community grant program application and review process.				X

3. The SAHC will continue to monitor the progress and effectiveness of the statewide abstinence media campaign and continue to disseminate educational materials to community-based grantees, teens, parents, and other youth-serving organizations.			X	
4. The SAHC will partner with other divisions within the Indiana State Department of Health to assist in the administration of the 2009 Youth Risk Behavior Survey (YRBS).				X
5. The SAHC will continue to lead the Indiana Coalition to Improve Adolescent Health. The coalition released the state's first adolescent health plan in May 2009. One of the priorities of the coalition is to address risky sexual behaviors.				X
6. MCHSC is funding three school-based adolescent health clinics that may provide either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student.	X			
7. The SAHC currently is a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy.				X
8. The SAHC promoted the 2009 National Day to Prevent Teen Pregnancy by ensuring a press release from the Indiana State Department of Health & coordinating announcements regarding the National Day to be sent to all school superintendents & principals.				X
9. SAHC attended a sexual health summit for adolescents in April 2009.				X
10.				

b. Current Activities

b. FY 2009 Current Activities

The state adolescent health coordinator (SAHC) submited all necessary documentation and paperwork to ensure continuation of federal Abstinence Education Block Grant funds through fiscal year 2013. (Grant application was approved for fiscal years 2009-2013).

The SAHC oversees the FY2010-2011 Indiana RESPECT community grant program application and review process. SAHC will update the grant application and hold a technical assistance meeting for all interested applicants.

The SAHC monitors the progress and effectiveness of the statewide abstinence media campaign and continue to disseminate educational materials to community-based grantees, teens, parents, and other youth-serving organizations. SAHC will ensure that the Indiana RESPECT website will be redesigned and launched by July 2009.

The SAHC partners with other divisions within the Indiana State Department of Health to assist in the administration of the 2009 Youth Risk Behavior Survey (YRBS).

The SAHC leads the Indiana Coalition to Improve Adolescent Health. The coalition released the state's first adolescent health plan in May 2009. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.

MCHSC is funding three school-based adolescent health clinics that may provide either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

The SAHC will continue to oversee Indiana RESPECT grantees supported with state funds. The SAHC will provide training as necessary to the grantees on topics such as science-based approaches to teen pregnancy prevention and data collection and evaluation.

The SAHC will continue to monitor all aspects of the media campaign for Indiana RESPECT, including the placement of TV advertisements, website advertisements, hits to Indiana RESPECT's website, dissemination of education materials, and a presence at community events. The SAHC will ensure quarterly updates to the website in order to keep the site updated with new information that will encourage visitors to return to the site.

MCHSC will fund three school-based adolescent health clinics that may provide either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student. SAHC is the liaison for the clinics and will provide any technical assistance or educational materials, as requested.

The SAHC will continue to facilitate the Indiana Coalition to Improve Adolescent Health. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.

The SAHC will promote the 2010 National Day to Prevent Teen Pregnancy. The SAHC will work internally with other programs at the Indiana State Department of Health and collaborate with the Indiana Department of Education to share information regarding this initiative with schools, teachers, community members, and grantees of Indiana RESPECT.

The SAHC, if given the opportunity, will continue to serve as a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy, STD's, and HIV among adolescents and translate this research into user-friendly materials to disseminate to the field.

The SAHC will assist with the dissemination of data from the 2009 Youth Risk Behavior Survey (YRBS) and prepare the fact sheet for adolescent sexual behaviors.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	42.7	46	47	48	49
Annual Indicator	45.1	44.5	47.1	48.7	49
Numerator					
Denominator					
Data Source					ISDH - Oral Hlth
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	51	52	53	54

Notes - 2008
Projected based on last year's information from ISDH Oral Health program.

Note: This survey has not been done since 2005. It will not be done again until 2010. Projection based on information provided by the ISDH Oral Health Program in 2006 as well as data from 2005 and earlier.

Notes - 2007
Projected based on last year's information from ISDH Oral Health program.

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This means that, based on our revised projection, we met our goal for 2007.

Notes - 2006
Projected based on last year's information from ISDH Oral Health program.

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This revises 2006's figure and actually means that, based on our final revised projection, we met out goal for 2006.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 48% in FY 2008.

Status: Unable to determine. Statewide data on sealant placment for third grade children is not available.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

OHS promoted community-based dental sealant programs, and collaborated with the IU School of Dentistry Community Dentistry's Seal Indiana program, St Mary's Mobile Unit, Smile Indiana Mobile Program and the Marion County Smile Mobile Program.

OHS encourages dental providers to participate in Hoosier Healthwise and use sealants with Hoosier Healthwise clients to help eliminate disparities in preventive services rendered.

OHS met quarterly with the members of the Oral Health Task Force (OHTF) and collaborated with these community experts on drafting the State Oral Health Plan, which will increase dental services to the underserved.

OHS coordinated a 16-page oral health insert titled, "Healthy Mouth, Healthy Life" which was included in the November 2008 issue of Indianapolis Women magazine. This insert provided

relevant information for the consumer on the importance of good oral health. Oral health information related to oral health during pregnancy, early child care and the beneficial use of sealants was provided. This magazine had a circulation of more than 200,000.

OHS met quarterly with the Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory work group on oral health issues.

OHS distributed oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish and provides educational training presentations when requested.

OHS collaborated with Indiana University School of Dentistry and Indiana University School of Public and Environmental Affair's, Center for Health Policy and received a HRSA Oral Health Services Systems grant to identify key state oral health priorities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OHS will utilize grant dollars to enhance and support sealant projects already in existence in Title I schools by current dental mobile providers.	X			
2. OHS will promote community-based dental sealant programs, among existing programs and will continue to collaborate with the IU School of Dentistry Community Dentistry's sealant placement program to develop specific pilot school programs.				X
3. OHS will utilize grant dollars to develop specific sealant projects in rural schools to begin in FY2010.	X			
4. OHS will encourage dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.				X
5. OHS will continue to consult with Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory work group on oral health issues by attending quarterly meetings or as needed to accomplish the business at hand.				X
6. OHS will promote the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry, and all Dental Hygiene Programs (5) and to current practitioners throughout the state.	X			
7. OHS will continue to provide oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish.		X		
8. OHS will collaborate with partners such as the IU School of Dentistry, Indiana Dental Association, Indiana Dental Hygienists Association, Indiana Rural Health Association, Indiana Primary Health Care Association and other partners in the state.				X
9. OHS will help communities gain designation as a Dental HPSA and collaborate with ISDH Primary Care Director to accomplish this.				X
10. OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within				X

existing and future Community Health Centers (CHC).				

b. Current Activities
b. FY 2009 Current Activities

OHS utilizes MCH grant dollars to enhance and support sealant projects already in existence in Title I schools by current dental mobile providers.

OHS promotes community-based dental sealant programs, among existing programs and will continue to collaborate with the IU School of Dentistry Community Dentistry's Seal Indiana sealant program to develop specific pilot school programs to help increase sealant placement to third graders.

OHS encourages dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

OHS continues to consult with Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory work group on oral health issues by attending quarterly meetings or as needed to improve access to quality oral health care.

OHS promotes the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry, and all Dental Hygiene Programs (5) and to current practitioners throughout the state.

The State Oral Health Director is collaborating with the Center for Health Policy and the Indiana University School of Dentistry on a HRSA funded project that will, set up the Statewide Planning Council, conduct a statewide oral health needs assessment, identify priority oral health needs and develop a preliminary strategic oral health plan.

OHS will help communities gain designation as a Dental HPSA.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

State Oral Health Director will work with other ISDH personnel and partners to identify components of the Strategic Oral Health Plan that can be implemented with available resources.

State Oral Health Director will issue the final report on the Strategic Oral Health Plan project which will include recommendations for state oral health priorities.

State Oral Health Director will work with partners to obtain funding to implement the Strategic Oral Health Plan.

OHS will seek grant dollars or other funding to enhance and support sealant projects already in existence in Title V schools by current dental mobile providers.

OHS will promote community-based dental sealant programs, among existing programs and will continue to collaborate with the IU School of Dentistry Community Dentistry's Seal Indiana sealant program to develop specific pilot school programs to help increase sealant placement to third graders.

OHS will encourage dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

OHS will continue to consult with Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory work group on oral health issues by attending quarterly meetings or as needed to accomplish the business at hand.

OHS will promote the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry, and all Dental Hygiene Programs (5) and to current practitioners throughout the state.

OHS will seek out funding that can be utilized to help communities gain designation as a Dental HPSA.

OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3	3	3.4	3.2	3
Annual Indicator	4.3	3.3	3.5	3.2	3
Numerator	57	44	46	44	
Denominator	1330543	1326607	1301093	1375000	
Data Source					ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.8	2.6	2.5	2.4	2.3

Notes - 2008
Projected based on data provided in previous years.

Source of data: ISDH - ERC

Notes - 2007
Fluctuating figure; expected to decrease next year. Estimated (projected) to be 3.2. Actual numerator provided; denominator will be corrected with information from the USCB site. Temporarily denominator calculated from projected rate and actual numerator.

Source of data will be US Census Bureau; ISDH ERC.

Notes - 2006

Projection based on last year's data. 2006 data will not be complete per ISDH ERC until all figures are in to Vital Records and subsequently analyzed. VR does not get them from other states until September, so this will always be a provisional figure.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease to 3 in 2008.

Status: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children were 3.0 in 2008.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

ISDH funded a part-time injury epidemiologist for the ISDH Injury Prevention Program.

ISDH coordinated periodic meetings of the Injury Prevention Advisory Council.

ISDH continued work on the updated version of "Injuries in Indiana" data report, which has an entire section which focuses on motor vehicle crashes and issues related to adolescent driving.

ISDH coordinated information on preventing deaths and injuries from teen motor vehicle crashes as a prevention priority contained in the newly developed State Strategic Plan for Indiana's Adolescents.

ISDH promoted automobile safety through participation in relevant local/state programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ISDH continues to fund a part-time epidemiologist for the ISDH Injury Prevention Program through August 31, 2009.		X		
2. ISDH continues to coordinate periodic meetings of the Injury Prevention Advisory Council.				X
3. ISDH completed the work on the updated version of “Injuries in Indiana” data report that has an entire section which focuses on motor vehicle crashes and issues related to adolescent driving.		X		
4. ISDH will coordinate information on preventing deaths and injuries from teen motor vehicle crashes as one topic area in the current development of an Indiana Adolescent Health Plan.		X		
5. ISDH is promoting automotive safety through participation in relevant local/state programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

ISDH funds a part-time epidemiologist for the ISDH Injury Prevention Program through August 31, 2009.

MCH Medical Director and Perinatal and Child Health Nurse Consultant are meeting with representatives of the State Child Death Review Program to find ways to increase collaboration.

ISDH coordinates periodic meetings of the Injury Prevention Advisory Council.

ISDH completed the work on the updated version of "Injuries in Indiana" data report that has an entire section which focuses on motor vehicle crashes and issues related to adolescent driving.

ISDH provided educational materials and data sources to the Indiana Coalition to Improve Adolescent Health to support the information on motor vehicle crashes among the teen population as outlined in the state adolescent health plan.

ISDH is promoting automotive safety through participation in relevant local/state programs.

MCH staff will explore how to increase involvement in Injury Prevention activities and dissemination of information from the Child Death Review Process.

c. Plan for the Coming Year
c. Planned Activities FY 2010

ISDH will continue to work with the Injury Prevention Advisory Council to ensure information is shared with internal and external partners concerning programs and activities involving injury prevention.

ISDH will provide educational materials and data sources to the Indiana Coalition to Improve Adolescent Health to support activities addressing motor vehicle crashes among the teen population as outlined in the state adolescent health plan.

ISDH will continue to promote automobile safety through participation in relevant local/state programs.

MCSHC will thoroughly review injury data during 5 year Needs Assessment Process.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			35	31	35
Annual Indicator		29.2	30.2	34.6	35.4
Numerator					
Denominator					
Data Source					US CDC Report
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	36	37	38	39	40

Notes - 2008
Projection based on US CDC report which should be updated late summer/early fall.

Source of data: US CDC report.

Notes - 2007
Source of data: US CDC report.

Notes - 2006
Source of Data: ISDH WIC program.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percentage of mothers who breastfeed their infants at 6 months of age will be 35% in FY 2007.

Status: 35.4% in 2007 based on USCDC Report.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

A new State Breastfeeding Coordinator (SBC) was hired in January 2008 to work with local coalitions around the state and facilitate communication between the Indiana Breastfeeding Alliance and the local coalitions. She began the work of supporting and helping form coalitions around the state.

A new law was passed by the state legislature, SEA 219, which requires all state agencies and businesses with 25 or more employees to make reasonable accommodations for employees who need to pump breastmilk for their baby during the workday. The employer must provide a private spot to pump other than a bathroom stall, either a refrigerator or allowance for employee's own personal cold storage device for storage of pumped milk and ability to pump whenever employee is away from their assigned duties.

Indiana was one of ten states chosen in January 2008 to pilot HRSA's The Business Case for Breastfeeding (BCBF), a worksite lactation program. With the passage of SEA 219, the SBC kept very busy traveling the state, meeting with businesses and local coalitions, many by request, to consult, using the HRSA materials about the importance and means of providing the accommodations required by the new law.

The annual coalition conference was held May 2008 with representatives of sixteen coalitions from around the state attending. The graphic pieces of the Breastfeeding Media Campaign were presented, with printer-ready versions distributed to coalitions around the state via disk and internet download in time for use with World Breastfeeding Week, August 1--7. HRSA's The Business Case for Breastfeeding also was presented and materials handed out for use by the coalitions in their communities.

The American Academy of Pediatrics Indiana Chapter Breastfeeding Coordinator was elected to the Academy of Breastfeeding Medicine Board of Directors in 2008 and has been nominated to the Executive Committee of the American Academy of Pediatrics Section on Breastfeeding. She is also an active member of the Indiana Breastfeeding Alliance (IBFA) and conducted physician trainings around the state. Additionally, she has co-authored at least two breastfeeding related articles which were published in professional peer-reviewed journals in 2008, based on activities and cases within the state.

A fourth Milk Depot was opened at a WIC site in Lafayette to collect milk donations for the Indiana Mothers Milk Bank (IMMB). The First Lady of Indiana, Cherie Daniels, was the keynote speaker at this well-publicized event.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The SBC has continued actively working with local coalitions all over the state, increasing the number of coalitions 400%, from 8 to 32, a number that is still increasing.				X
2. IPN established an 800 number 'Workplace Lactation Line', for questions regarding the new workplace lactation law, some of which have come from childcare providers, as well as businesses and employee.			X	
3. IPN held a training opportunity in November 2008, in accordance with HRSA specifications, for individuals wishing to actively assist with HRSA's Business Case for Breastfeeding program to outreach to employers and employees.				X
4. The Indiana Perinatal Network received the 2008 STAR Community/Philanthropic Award, a leading statewide honor for associations and not-for-profits, for its Breastfeeding Promotion Initiative.			X	
5. The Indiana Breastfeeding Alliance (IBFA) formalized bylaws and elected new officers. A new action list was developed at the February 2009 meeting and steps are being taken to increase both membership and collaborative efforts at the state level.				X
6. IPN has updated its website, including an expanded section on breastfeeding information, links and resources. The SBC is also sending out a monthly Breastfeeding Update e-newsletter.		X		
7. The Indiana Black Breastfeeding Coalition (IBBC) continues to "promote, empower, embrace, & encourage mothers, fathers, infants, & family members in the African American community through community outreach, education, & advocacy for breastfeeding".		X		
8. WIC is providing a five day Lactation Specialist Course, open to WIC staff and non WIC community partners. Those attending all session's and passing an exam will receive a LSC certification.				X
9. WIC is planning six opportunities to attend 'WIC: Building Bridges/Connecting Bridges' at Indiana Hospitals in 2009, and will host an Advanced Lactation Day for Lactation Consultants interested in the newest breastfeeding research.				X
10. The ISDH Division of Nutrition and Physical Activity received a large grant from the CDC, in which one of the six target areas				X

is to increase breastfeeding support.				

b. Current Activities
b. FY 2009 Current Activities

The SBC has continued actively working with local coalitions increasing the number of coalitions 400%, from 8 to 32, a number that is still increasing.

Indiana Perinatal Network (IPN) established an 800 number 'Workplace Lactation Line', for questions regarding the new workplace lactation law, which come from childcare providers, businesses and employees.

IPN held a training in November 2008, in accordance with HRSA specifications, for individuals wishing to actively assist with HRSA's Business Case for Breastfeeding program to outreach to employers and employees.

IPN received the 2008 STAR Community/Philanthropic Award, a leading statewide honor for associations and not-for-profits, for its Breastfeeding Promotion Initiative.

The Indiana Breastfeeding Alliance (IBFA) formalized bylaws and elected new officers, including the MCH Nurse Consultant as Vice Chair.

The Indiana Black Breastfeeding Coalition (IBBC) continues to 'promote, empower, embrace, and encourage mothers, fathers, infants, and family members in the African American community through community outreach, education, and advocacy for breastfeeding and the use of human milk. Additionally, a second IBBC has been formed in northern Indiana.

WIC is providing a five day Lactation Specialist Course, open to WIC staff and non WIC community partners. Those attending all sessions and passing an exam will receive a LSC certification.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

The SBC will continue to build and support local coalitions around the state, serving as the liaison between the IBFA and the local coalitions. She will also continue to educate local communities about the BCBF and to advance the other objectives of the IBFA, as well as to inform the IBFA of issues in the state that require action or discussion.

The two IBBCs will continue to strengthen their coalitions and expand their work in the African-American community to improve breastfeeding promotion and support.

The IBFA will continue to collaborate with the IN Healthy Weight Initiative to devise strategies for improving breastfeeding support in the state.

The SBC will continue to work collaboratively with IPN, the IBFA, and individual coalitions to implement and promote The Business Case for Breastfeeding.

The IBFA will work toward getting insurance coverage of lactation consultation and supplies, and to create a registry of International Board Certified Lactation Consultants in the state.

The IBFA will continue to seek new members and collaborative partners and will complete an update of the Call to Action to Promote Breastfeeding in Indiana.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99	98.4	98.6	99.6	99.7
Annual Indicator	97.9	99.6	97.8	98.1	98.3
Numerator	86077	87371			
Denominator	87927	87685			
Data Source					ISDH - UNHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98.5	98.7	98.9	99.1	99.3

Notes - 2008
:rogram would not allow objective change for 2008; if it had, the porjection would have been changed to 98.3 (and met), due to the final figures having been corrected for 2006 and 2007.

Source of data: ISDH UNHS

Notes - 2007
Provisional based on trend analysis.

Source of data will be ISDH UNHS/EHDI Program(s)

Notes - 2006
ISDH ERC and UNHS verifyied questionable immunization data. Final figure revised to reflect actual figure.

Source of data: ISDH UNHS

a. Last Year's Accomplishments
FY 2008 Performance Objective: Improve universal newborn hearing screens to 98.8% in FY 2008.

Status: The data used for this objective refers to the most recent data that the Early Hearing Detection and Intervention (EHDI) program reported on the Centers for Disease Control (CDC) Annual Survey in February 2009. For Calendar Year 2008, 98.3% of newborns were screened prior to hospital discharge. (Provisional Data Used)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

Trained 89 birthing hospitals on EARS, a web-based program that allows hospitals to immediately report children who have referred from Universal Newborn Hearing Screening (UNHS) to the ISDH EHDI program.

Provided 4 trainings and scheduled an additional 6 visits to physicians and physician resident groups to provide information regarding screening and follow-up for babies.

Provided 13 trainings to audiologists and other direct service early intervention providers, early intervention intake and service coordinators, and hospital screening personnel.

Contacted three large birthing practices and/or facilities which serve large Amish populations to begin assisting these communities in completing UNHS screenings.

Developed a Memorandum of Understanding (MOU) that will allow loaner hearing screening to be placed in facilities outside of ISDH.

Posted two reminders about the IBDPR reporting requirement to in-state electronic newsletters that reach physicians (i.e. Indiana chapters of the American Academy of Pediatrics and the American Academy of Family Practitioners).

Developed a toolkit for First Steps (Part C) Early Intervention personnel to use with parents of children undergoing the EHDI process.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to work with individual hospitals to encourage timely and complete reporting of their children. EHDI has nearly completed a transition to a new data management system (EARS).				X
2. Continue to visit hospitals in their respective regions of the state to provide education and assist with issues related to screening, follow-up and reporting.				X
3. Continue to provide educational presentations to hospitals, public health nurses (PHN), students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and processes.				X
4. Continue efforts to educate physicians regarding follow-up results of referred children from UNHS.				X
5. Continue to work with public health nurses at local health departments to promote awareness of EHDI and the importance of follow-up.				X
6. Participate in training at least one midwife facility, which sees a large Amish population, in the next few months.				X
7. Continue to refine MCH reporting mechanisms through EARS and the Indiana Data System (IDS). The IDS allows sharing of information from Vital Records.				X
8. Continue partnership with Indiana Hands & Voices to provide family education and support opportunities.				X
9. ISDH Vital Records information will be shared with EARS, thereby providing EHDI staff with information from all children				X

born within the state including those children born at home.				
10. Continue to work with Level 1 centers and with centers interested in Level 1 status to maximize services for young infants and babies.				X

b. Current Activities

b. FY 2009 Current Activities

Continue to work with individual hospitals to encourage timely and complete reporting of their children. EHDI has nearly completed a transition to a new data management system (EARS).

Continue to visit hospitals in their respective regions of the state to provide education and assist with issues related to screening, follow-up & reporting.

Continue to provide educational presentations to hospitals, public health nurses (PHN), students, physicians, audiologists, early interventionists, & other interested parties regarding EHDI goals, objectives and processes.

Continue efforts to educate physicians regarding follow-up results of referred children from UNHS.

Continue to work with public health nurses at local health departments to promote awareness of EHDI & the importance of follow-up.

Participate in training at least one midwife facility, which sees a large Amish population, in the next few months.

Continue to refine MCH reporting mechanisms through EARS and the Indiana Data System (IDS). The IDS allows sharing of information from Vital Records.

Continue partnership with Indiana Hands & Voices to provide family education & support opportunities.

ISDH Vital Records information will be shared with EARS, thereby providing EHDI staff with information from all children born within the state including those children born at home.

Continue to work with Level 1 centers and with centers interested in Level 1 status to maximize services for infants & babies.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

EHDI will lead our state's involvement in a learning collaborative through the National Institute on Child Health Care Quality (NICHQ) (funded by the Health Services and Resources Administration [HRSA]) to improve UNHS and EHDI follow-up.

EHDI will initiate a new parent-to-parent mentor program, "Guide By Your Side," in partnership with Indiana Hands & Voices.

Working the EHDI Advisory Committee, a physician's toolkit will be completed and given to providers of children who have been identified with a hearing loss through the EHDI program.

EHDI will continue to train hospitals on updates related to newborn hearing screening, follow-up and the EARS data management system.

EHDI will provide comprehensive performance data to individual birthing facilities, commendations and recommendations to improve rate of screening and referrals to the medical home, early intervention, and the EHDI program.

EHDI will train the fourteen birthing hospitals not yet trained on the EARS system.

EHDI will assist at least two nurse/midwife facilities in obtaining screening equipment.

EHDI will continue to target midwifery facilities for implementation of UNHS.

EHDI will work with the Indiana University Laboratory (which receive heel stick cards for babies), to look at discrepancies between electronic reporting screening results via the heel stick card versus hospital screening program reporting in the EARS system.

HDI will provide two large trainings to audiologists on audiology procedures and related content areas to increase the skills, knowledge base and number of providers who serve very young babies and children.

EHDI, in partnership with the Indiana Chapter of Hands & Voices, will update the Indiana Family Resource Guide for Families with Children with Hearing Loss, and translate the guide into Spanish.

EHDI staff will develop a specialized Parent Toolkit for parents of children identified with unilateral or mild hearing loss.

EHDI staff will work with the Region IV Genetics Collaborative EHDI subcommittee to complete protocols for referring children for genetic counseling and genetic workup.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	12	8.7	9.5	8.5
Annual Indicator	8.9	9.5	10.0	9.0	8
Numerator	144000	161260	158000	141990	
Denominator	1617977	1689985	1577629	1577667	
Data Source					Kids Count Bk
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.5	7	6.5	6	5.5

Notes - 2008

Source of data: Kids Count book (Ann Casey/Robert Wood Johnson Foundation); US Census Bureau.

Note: This is children age 17 and below.

Notes - 2007
Source of data: Kids Count book (Ann Casey/Robert Wood Johnson Foundation); US Census Bureau.

Note: This is children age 17 and below.

Notes - 2006
Provisional estimate from Robert Wood Johnson foundation figures and US Census Bureau figures.

a. Last Year's Accomplishments
Performance Objective: To decrease the percent of children without insurance to 8.5% in FY 2008.

Status: Met at 8.0% ** Note: Projected percentage based on Ann E. Casey "Kid's Count" data book. Figures improved consecutive years. Projection as steady (2006 actual). Final figure will be provided when available.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

The MCHB funded project, the Indiana Early Childhood Comprehensive System Program (aka. Sunny Start) continued to include strategies to increase the percentage of children on child care voucher programs who have health insurance.

The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program provided service information to families via a website. The website will be expanded to include more information.

MCSHC grantees served as enrollment sites for Hoosier Healthwise and/or referred clients to local Hoosier Healthwise enrollment sites.

The Indiana Family Helpline provided referrals and screens clients for Hoosier Healthwise eligibility.

MCSHC required all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees facilitated children into Hoosier Healthwise.

The MCH Director served on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and participated on the Hospital & Health Center subcommittee.

MCSHC staff participated in the Department of Family Resources Partnership subcommittee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCHB funded project, the Indiana Early Childhood		X		

Comprehensive System Program continues to include strategies to increase the percentage of children on child care voucher programs who have health insurance.				
2. The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program continues to provide service information to families via a website. The website will be expanded to include more information.				X
3. MCSHC grantees continue to serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.				X
4. The Indiana Family Helpline continues to provide referrals and screens clients for Hoosier Healthwise eligibility.		X		
5. MCSHC continues to require all grantees providing primary care to children to be Medicaid providers.		X		
6. MCSHC Family Care Coordination grantees continue to facilitate children into Hoosier Healthwise. Emphasis on doing so will be increased.		X		
7. The MCSHC Director continues to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.				X
8. MCSHC staff continues to participate in the Department of Family Resources Partnership subcommittee.				X
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

Sunny Start includes strategies to increase the percentage of children on child care voucher programs who have health insurance. Twenty two financial fact sheets have been developed for families including information on Medicaid and SCHIP.

Sunny Start: Healthy Bodies, Healthy Minds initiative provides service information to families via a website. The website will be expanded to include more information.

MCSHC grantees serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.

The Indiana Family Helpline provides referrals and screens clients for Hoosier Healthwise eligibility.

MCSHC requires all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees facilitate children into Hoosier Healthwise. Emphasis on doing so is being increased.

The MCH Director serves on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and participated on the Hospital & Health Center subcommittee.

MCSHC staff participates in the Department of Family Resources Partnership subcommittee.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program will continue to provide service information to families via a website. The website will be expanded to include more information. Financial Fact sheets will be kept updated.

MCSHC grantees will continue to serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.

The Indiana Family Helpline will continue to provide referrals and screen clients for Hoosier Healthwise eligibility.

MCSHC will continue to require all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees will continue to facilitate children into Hoosier Healthwise. Emphasis on doing so will be increased.

MCH staff will continue to work with Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.

MCSHC staff will continue to participate in the Department of Family Resources Partnership subcommittee.

Sunny Start and C.I.S.S. grant project staff will collaborate to increase information to families.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			23	49	17
Annual Indicator		23.0	17.5	29.8	30.8
Numerator		18232	14862	20391	24218
Denominator		79406	84925	68500	78700
Data Source					ISDH - WIC pgm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	29	28	27	25

Notes - 2008

Note for 2006: Program would not allow correction of spelling in 2006 note. "WUC" should be "WIC.

"Figures provided for CY 2005 by WIC program may have been in error. Actual figures for CY 2006 from the WIC program are 14862 (numerator) and 17.5% (denominator calculated from those to be 84975). This would be much closer to the original WIC estimates for CY 2005 (18232/79406=23%) and show a marked decrease due to our effective programs. The corrected but suspect figures for CY 2005 are being checked by WIC at this time.

Update: Percentages provided for 2007 (29.8%) and 2008 (30.8%) WIC seem quite high, but may reflect that the original objective of 49 for 2007 was too high but the 2008 objective should not have been lowered by such a large amount. Of course, the program will not allow changes for objectives of of 2007 and 2008 which would have been 35% and 31% respectively & thus objectives would have been met both years. With the numerator and percentage provided by the WIC program for 2007 and 2008, the denominator is a calculated figure.

Source of data: ISDH - WIC program

Notes - 2007
Figures provided for CY 2005 by WIC program may have been in error. Actual figures for CY 2006 from the WIC program are 14862 (numerator) and 17.5% (denominator calculated from those to be 84975). This would be much closer to the original WIC estimates for CY 2005 (18232/79406=23%) and show a marked decrease due to our effective programs. The corrected but suspect figures for CY 2005 are being checked by WIC at this time. Final figures for CY 2005 will be entered into the historical notes when available. Source of data: ISDH WIC program. Application would not allow change of 2007 objective. Actual objective would be 17.5%.

Update: Percentages provided for 2007 (29.8%) and 2008 (30.8%) WIC seem quite high, but may reflect that the original objective of 49 for 2007 was too high but the 2008 ojective should not have been lowered by such a large amount. Of course the program will not allow changes for objectives of 2008 (see 2008 note).

Notes - 2006
Corrected information for this historical note (also see note for 2007):

Figures provided for CY 2005 by WIC program may have been in error. Actual figures for CY 2006 from the WIC program are 14862 (numerator) and 17.5% (denominator calculated from those to be 84975).

This would be much closer to the original WUC estimates for CY 2005 (18232/79406=23%) and show a marked decrease due to our effective programs.

The corrected but suspect figures for CY 2005 are being checked by WIC at this time. Final figures for CY 2005 will be entered into the historical notes when available.

Source of data: ISDH WIC program (see original historical note below for further details).
==========
WIC information provided to us a correction for CY2005 for baseline figures. However, the TVIS application would not let us change CY2005's figures; here are the actuals:

CY2005 Numerator: 25320
CY2005 Denominator: 51472

Which equals 49.2%.

The previous figure of 23% did not include >95% numbers.

CY2006 figure estimated based on CY2005 actuals.

Source of data: ISDH WIC Program

a. Last Year's Accomplishments
FY 2008 Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be 31%.

Status: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile was 30.8% in 2008.

a. FY 2008 Accomplishment

Activities that impacted this Performance Objective included:

WIC health professionals screened all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals also screened all children for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI 85% to < 95%) status using height for weight BMI.

WIC health professionals assessed WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHCS clinics also assessed children's diets for nutrition and eating habits that would impact growth patterns.

When appropriate, WIC provided counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. When appropriate, MCSHCS clinics provided guidelines on healthy eating habits and physical activity to families and children.

WIC displayed posters/bulletin boards on physical activity, nutrition and healthy eating. MCSHCS clinics displayed posters and created bulletin boards communicating information on physical activity, nutrition and healthy eating habits.

WIC provided educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics provided educational information (handouts/fliers) on healthy eating and physical activity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%).	X			
2. WIC health professionals are assessing WIC eligible children's' diets for nutrition & feeding practices that would affect growth patterns. MCSHCS clinics are assessing children's diets for nutrition & eating habits that would impact growth patterns.	X			
3. When appropriate, WIC are providing counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCSHCS clinics are providing guidelines on healthy eating habits.	X			
4. WIC is displaying posters/bulletin boards on physical activity,			X	

nutrition and healthy eating. MCSHCS clinics is displaying posters and creating bulletin boards communicating information on physical activity, nutrition and healthy eating habits.				
5. WIC are providing educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics are providing educational information (handouts/fliers) on healthy eating and physical activity.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

WIC health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals are also screening all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI85% to < 95%) status using height for weight BMI.

WIC health professionals and MCSHCS clinics are assessing WIC and MCSHCS eligible children's' diets for nutrition and feeding practices that would affect growth patterns.

When appropriate, WIC are providing counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCSHCS clinics are providing guidelines on healthy eating habits and physical activity to families and children.

WIC is displaying posters/bulletin boards on physical activity, nutrition and healthy eating. MCSHCS clinics is displaying posters and creating bulletin boards communicating information on physical activity, nutrition and healthy eating habits.

WIC is providing educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics are providing educational information (handouts/fliers) on healthy eating and physical activity.

MCH and WIC staffs are participating in the Indiana Healthy Weight Initiative Coalition developed by the ISDH Nutrition and Physical Activity Program.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

WIC health professionals will screen all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals will also screen all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI85% to < 95%) status using height for weight BMI.

WIC health professionals will assess WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHCS clinics will assess children's diets for nutrition and eating habits that would impact growth patterns.

When appropriate, WIC will provide counseling to families of WIC eligible children that will include

physical activity ideas and healthy eating information. Where appropriate, MCSHCS clinics will provide guidelines on healthy eating habits and physical activity to families and children.

WIC will provide educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics will provide educational information (handouts/fliers) on healthy eating and physical activity.

MCH and WIC staff will serve on subcommittees for the Indiana Healthy Weight Initiative including the Early Childhood and Breastfeeding workgroup.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			16.1	15.8	15.6
Annual Indicator		16.2	15.9	17.3	15.7
Numerator			15589	17005	
Denominator			97788	98408	
Data Source					ISDH - VR
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15.6	15.5	15.4	15.3	15.2

Notes - 2008
Percentage provided by ISDH VR

Source of data: ISDH Vital Records (Birth Certificate Information)

Notes - 2007
Percentage and numerator provided by ISDH VR; denominator calculated.

Source of data: ISDH Vital Records (Birth Certificate Information)

Notes - 2006
Information estimated based on number of women who reported smoking on birth certificates. All of those who reported smoking on the birth certificate were definitely smoking during the final trimester. This is probably close to the actual percentage, as it only omits women who smoked through the end of their second trimester but quit prior to delivery.

Source of data: ISDH Vital Records (Birth Certificate Information)

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.3% in FY 2008.

Status: 2008 Electronic Birth Certificate data shows 15.7% of pregnant women were smoking in third trimester**The Indiana birth certificate was changed in 2007 to conform to new national standards in the US Birth Certificate set in 2003. This affected many variables, including maternal smoking. The data, therefore, may not be strictly comparable to data of prior years.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective include:

ISDH continued to facilitate a legislative Prenatal Substance Abuse Commission (PSAC) on prenatal smoking, alcohol, and drug use to develop a strategic plan. Meetings were held bi-monthly. An interim report was submitted to the legislature in August 2008. Efforts are ongoing to pursue funding and implementation of the recommendations which include health care provider education and developing an ongoing monitoring system.

The ISDH Prenatal Substance Use Prevention Program (PSUPP) identified 4,850 high risk, chemically dependent pregnant women and provided counseling and intervention. They also began collaborating with Indiana Access to Recovery, a program to assist substance users in getting the professional help they need to quit. This program includes pregnant women as one of their target groups.

PSUPP/MCSHC continued their collaboration with Indiana Tobacco Prevention and Cessation (ITPC) to have greater impact on smoking cessation with pregnant women. The Indiana Tobacco Quit Line expanded its follow-up to pregnant women who now receive 10 calls instead of five calls.

PSUPP and all MCSHC-funded prenatal clinics incorporate education of women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

A training of physician representatives of all 3 Medicaid Contracted MCO's on smoking cessation, evidence based assessment tools, the 5A's, 5R's and the Indiana Tobacco Quitline was completed in the Spring by Clarian Tobacco Control Center, a member of the Indiana Coalition to Prevent Smoking in Pregnancy (CPSP).

All ITPC County Coalitions have been trained in the ACOG prenatal provider office training model and are replicating the in-office training in 80 counties. These community-based networks are also implementing strategies based on the Clinical Practice Guideline for Treating Tobacco Use and Dependence, such as establishing cessation networks and changing policies throughout the community.

MCSHC worked with Indiana Perinatal Network (IPN) and IN ACOG to disseminate information on prenatal smoking cessation. On 3/20/2008, a Smoking Cessation Panel Discussion was conducted at the IPN State Forum: Controversies and Innovations in Perinatal Health. 120 persons attended the Forum.

MCSHC informed all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and Quitline materials promoting the Quit Line were made available to all funded prenatal projects.

MCSHC continued to participate on the OMPP Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients to decrease NICU admissions due to complications from prenatal smoking. Each MCO was expected to refer pregnant women to the Indiana Tobacco Quitline and each MCO developed a smoking cessation program.

MCSHC continued as a partner in the Coalition to Promote Smokefree Pregnancies with ITPC, Clarian, American Lung Association, and other agency members. The coalition collaborated to write a grant to ITPC to provide media campaigns targeted to women of child bearing age in all counties with a prenatal smoking rate of >29. The grant was awarded July 1, 2008. Clarian Tobacco Control Center is serving as the fiscal agent for the grant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ISDH continues to facilitate the legislative PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan.				X
2. All MCSHC Title V funded prenatal services are mandated to address Federal Performance Measure 8.				X
3. A prenatal smoking cessation training webinar on assessment and brief intervention has been completed (April, 09) and placed on the MCH website. All funded prenatal projects must access the webinar and complete the pre-post test by August 31, 2009.				X
4. MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine further training needs.				X
5. The ISDH Prenatal Substance Use Prevention Program continues to identify high risk, chemically dependent pregnant women and provide counseling and intervention, & distribute information about the impact of substance use when pregnant.	X			
6. MCSHC continues as a partner in the Coalition to Promote Smoke free Pregnancies. The coalition has worked together to develop media messages. The Medicaid Managed Care Organizations (MCOs) were invited to participate.				X
7. MCH continues to participate on the Office of Medicaid Policy and Planning Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients.		X		
8. MCH has worked closely with OMPP to share prenatal outcomes data. In March, 2009, linked Medicaid/vital records revealed that smoking among Medicaid pregnant women was significantly higher than for the state.				X
9. MCSHC is working with Indiana Perinatal Network to dedicate the May 2009 issue of the Perinatal Perspectives IPN Newsletter to prenatal smoking.		X		
10. Baby First Packets continue to be sent to Prenatal IFHL callers, which includes information on smoking cessation.		X		

b. Current Activities

b. FY 2009 Current Activities

ISDH continues to facilitate the legislative PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan. Dr. Nocon, the Commission Chair, presented information on assessment of, and brief intervention for, pregnant women at the Indiana ACOG conference in March 2009.

All MCSHC Title V-funded prenatal services are mandated to address Federal Performance Measure 15. Mandated activities include: 1) 100% of clients will be asked if they smoke or are

exposed to second hand smoke at time of enrollment and smoking status documented in chart, 2) All clients who state they are smoking at time of enrollment will be assessed using the stages of change model* and documented in chart, 3) All clients who state they are smoking at time of enrollment will be monitored at each visit for smoking status, 4) 100% of pregnant women will receive information on the hazards of smoking during pregnancy, 5) All patients smoking at time of enrollment will be enrolled in a cessation/treatment program or referred to a program if not available on site.

A prenatal smoking cessation training webinar on assessment and brief intervention has been completed (April, 2009) and placed on the MCH website. All funded prenatal projects must access the webinar and complete the pre/post test by August 31, 2009.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

Baby First Packets will be sent to Prenatal IFHL callers that include information on smoking cessation

MCH will continue to participate in the Coalition to Prevent Smoking in Pregnancy to reach out to health care providers and women of childbearing age in counties with high smoking rates to decrease prematurity, low birthweight, and exposure to second smoke among infants and children.

MCH will analyze prenatal smoking data through monthly data from the Notification of Pregnancy form and cessation outcomes of the new Prenatal Care Coordination program, Indiana Healthy Beginnings, for success and training needs.

MCH will continue to work with the Office of Medicaid Policy and Planning and the Medicaid Managed Care Organizations to decrease smoking among pregnant women on Medicaid.

Plans are to continue the work of the PSAC even if not legislatively mandated. Funds will be sought to implement recommendations particularly for provider education and interagency coordination.

MCH will continue to work with the Indiana Perinatal Network to provide prenatal smoking education to prenatal health care providers through forums and newsletters.

The PSUPP program will continue to collaborate with Indiana Access to Recovery program (ATR) to refer pregnant substance-using women to providers for needed services.

The Provider Resource List will be maintained and updated by the PSUPP Director for public use.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2004	2005	2006	2007	2008

Data					
Annual Performance Objective	8	8	8	6.9	7.1
Annual Indicator	8.1	6.9	7.3	7.2	7.1
Numerator	36	31	33		
Denominator	445489	450445	450758		
Data Source					ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.9	6.7	6.5	6.3	6.1

Notes - 2008
Data projected from past final data and provisional data provided for 2007 by ERC.

Source of data: ISDH - ERC

Notes - 2007
Fluctuating rate; Data from 2006 and previous years is now final.
Data from 2007 is provisional, provided by ERC.

Source of data: US Census Bureau, ISDH ERC

Notes - 2006
Estimate provided based on previous year's figures which are now final. Despite this measure fluctuating considerably, it is hoped we can maintain at CY2005's level of 6.9.

TVIS application did not allow changing objective for 2006; projected objective would have been changed to 6.9.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.7 in FY 2008.

Negotiated Performance Measure for Indiana Suicide Prevention Coalition ISPC: 50% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

Status: 7.1% in 2008

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

The Office of Primary Care has funded a full time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional Coalitions.

ISDH completed an updated data report on Suicide in Indiana, to be published electronically through the ISDH Program website.

ISDH continued its collaboration with the Indiana Suicide Prevention Coalition (ISPC) to implement the State Suicide Prevention Plan. Planned Coalition activities supporting goals in the Plan include Promoting importance of suicide prevention to interested organizations: Providing Power Point presentations on suicide prevention at conferences and meetings; target audiences include: DOC, Juvenile Justice, physicians, social services, employers, schools, colleges and universities, mental health/social workers, senior community providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminating suicide prevention materials to a variety of audiences by mail and at events.			X	
2. Organize members and local suicide prevention councils/coalitions to implement statewide awareness activities for National Suicide Prevention Week.				X
3. Write editorial and organize press release for National Suicide Prevention Week.			X	
4. Respond to media requests for interviews concerning suicide prevention.			X	
5. Summarize and present lessons learned from 2007 telephone survey to the four regions in Indiana where it was conducted.				X
6. Identify the cost & availability of billboard advertisements, including appropriate messaging, for reducing stigma surrounding suicide for use by regional councils.			X	
7. Finalize the updated Indiana Department of Education "Student Suicide" Manual.			X	
8. Collaborate with the Indiana Department of Education to design and pilot workshop to disseminate the new "Student Suicide" Manual.				X
9. Partner with Indiana Partnership to Prevent Violent Injury and Death to distribute Harvard University's "Means Matter" Report to targeted audiences and distribute information on "Counseling on Access to Lethal Means" (CALM) training.			X	
10.				

b. Current Activities

b. FY 2009 Current Activities

Organize members and local suicide prevention councils/coalitions to implement statewide awareness activities for National Suicide Prevention Week

Write editorial and organize press release for National Suicide Prevention Week

Respond to media requests for interviews concerning suicide prevention.

Provide technical assistance to individuals and organizations regarding suicide prevention,

intervention and postvention.

Provide technical assistance to existing Indiana suicide prevention councils/coalitions and encourage the development of new regional/local suicide prevention councils.

Disseminate information on evidence-based suicide prevention/intervention training and programs to: Community health centers, Schools and colleges, Employers, Correctional facilities, Senior community providers, Health care providers, and Clergy.

Provide suicide prevention training (QPR, safeTALK) to interested organizations and groups.

Provide suicide intervention training (ASIST) to interested organizations and groups.

Manage the Indiana Suicide Prevention Coalition.

Finalize the updated Indiana Department of Education "Student Suicide" Manual and Collaborate with the Indiana Department of Education to design and pilot workshop to disseminate the new "Student Suicide" Manual.

Work with the Indiana Coalition to Improve Adolescent Health in regard to the prevention priority on suicide which was included in the state's adolescent health strategic plan.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

Negotiated Performance Measure for ISPC: 70% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

If funds allow, ISDH may continue to fund the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional Coalitions.

ISDH may continue to collaborate with the Indiana Suicide Prevention Coalition to implement the State Suicide Prevention Plan. Planned Coalition activities supporting goals in the Plan include:

Partner with National Alliance on Mental Illness (NAMI) to design and or implement an anti-stigma campaign in two cities.

Distribute SPRC/SPAN Emergency Department brochures to ERs around the state

Create an e-network of survivor support group providers in Indiana

Create information packet of survivor resources for survivor support groups based on needs identified in DMHA funded Survivor Survey conducted in 2007

Promote QPR-T and/or American Association of Suicidology (AAS) & Suicide Prevention Resource Center's (SPRC) Assessing and Managing Suicide Risk clinician training to mental health clinicians, physicians, and social workers.

Distribute responsible reporting guidelines to media.

Encourage the inclusion of suicide risk assessment into pre-service training of the following providers: Mental health workers, health care providers, clergy, education professionals, correctional personnel.

Create and distribute list of media outlets for press releases and public service announcements to regional/county level suicide prevention councils/coalitions.

ISPC will lead efforts to support activities and programs to prevent suicide in partnership with the Indiana Coalition to Improve Adolescent Health and state adolescent health plan.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	58	77	80	81	78
Annual Indicator	78.5	77.4	70.3	77.4	78
Numerator	1002	947	893		
Denominator	1277	1224	1271		
Data Source					MCH Cons Pgm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	82	84	86	88

Notes - 2008
All data are for the calendar year and not the fiscal year.

Estimates provided based on CY2006 figures which are now final. CY2007 data is not yet available.

Source of data: ISDH MCH Consultant Program.

Notes - 2007
All data are for the calendar year and not the fiscal year.

Estimates provided based on CY2006 figures which are now final. CY2007 data is not yet available.

Source of data: ISDH MCH Consultant Program.

Because application did not allow changing the objective, the objective would actually be 77.

Notes - 2006
All data are for the calendar year and not the fiscal year.

CY2006 figures used. Source of data: ISDH MCH Consultant Program.

This major drop is a suspected outlier. Further checking into the hospitals identifying themselves as level three, especially considering name-changes, mergers, hospitals that no longer do deliveries, etc. will be required to ensure that this is an accurate figure. At the moment it is the best using the data supplied.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 82% in CY 2008.

Status: 78% based on 2008 data.

a. FY 2008 Accomplishments

Activities that impacted this performance objective included:

MCSHC, in collaboration with Indiana Perinatal Network (IPN) completed the update of the Hospital Levels of Care 9/30/08. The document was published and disseminated to providers and is placed on the IPN website. A state map shows the location of the 2 IIIC NICU's, 17 IIIB NICU's, and 2 level 111A NICU's. Most of the Level III NICUs are concentrated within 4 counties.

The Indiana Prenatal Care Guidelines update was completed September 30, 2008 and includes when to transport mothers and infants. They can be found on the IPN website.

An in depth analysis of birth data by hospitals lead to the report Hospital Level and Delivery Volume and Neonatal Mortality among Very Low Birth Weight Infants which was completed by MCH and published on the MCH website October, 2008.

MCSHC continued to attend monthly meetings of the Office of Medicaid Policy and Planning Quality Strategy Prenatal Workgroup. The group continues to address prenatal smoking and access to care.

A PCEP (Prenatal Continuing Education Program) training was hosted by St. Vincent hospital in Marion County, and included Vigo County and Franklin County hospitals. The training was completed June, 08.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Further assessment of the Hospital Level and Delivery Volume and Neonatal Mortality among Very Low Birth Weight Infants report. These results will be used the PCEP Train the Trainer initiative.				X
2. An MOU with a sub-specialty hospital will be obtained to provide a PCEP train-the trainer program with the sub-specialty hospital being trained to train feeder hospitals on appropriate assessment, care and transport.				X
3. MCSHC will work with Lake County hospitals to assess competency levels, how to do an equipment inventory, how to build a perinatal network.				X
4. Due to unusually high black infant mortality rates in St. Joseph (30.1) and Allen (31.1), a PPOR analysis will be conducted to identify areas of excess deaths to guide future activities and resources.				X

5. MCH worked closely with the Office of Medicaid Policy and Planning to share birth data by race and county. The finalized 2007 linked Medicaid singleton birth data was released March, 09 and shared with MCOs, and IPN and March of Dimes.				X
6. An in depth analysis of prematurity and low birthweight is being done by MCH looking at all maternal factors, incidence of inductions and cesareans by hospital, county, day and time.				X
7. An updated assessment of the state's perinatal system and status will be completed with assistance from IPN, regional perinatal networks, and others.				X
8. Efforts are underway to expand the state perinatal network membership and reach out to regions of the state to share educational and allow for grater participation in quarterly State Perinatal Advisory board meetings.				X
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

Further assessment of the Hospital Level and Delivery Volume and Neonatal Mortality among Very Low Birth Weight Infants report shows that VLBW infants born at level I hospitals were more likely to be less than 500 grams and less than 24 weeks of gestation and were less likely to be a multiple birth or cesarean delivery than those born at level III hospitals. The strongest predictor of delivery outside level III hospitals was the mother's county of residency, usually rural and not in close proximity to a Level III hospital and resulted in the highest neonatal mortality rate. Results of this study suggest that increased use of hospitals with level III neonatal care might reduce neonatal mortality among VLBW infants. Indiana needs to boost its efforts in increasing the delivery of VLBW infants in subspecialty hospitals. These results will be used in setting up the PCEP Train--The-Trainer initiative.

An MOU with a sub-specialty hospital will be obtained to provide a PCEP train-the trainer program with the sub-specialty hospital being trained to train feeder hospitals on appropriate assessment, care and transport. This will serve as a pilot to implementing this program statewide in 2010.

Due to unusually high black infant mortality rates in St. Joseph (30.1) and Allen (31.1), a PPOR analysis will be conducted to identify areas of excess deaths to guide future activities and resources.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

An MOU with another sub-specialty hospital will be completed to provide a PCEP train-the trainer program with the sub-specialty hospital being trained to train feeder hospitals on appropriate assessment, care and transport.

The Perinatal Initiative will have a state plan and a report will be completed.

Training of prenatal care providers on universal screening for alcohol, tobacco and other drugs and brief interventions will be completed by the fourth quarter.

MCH will continue to work closely with the Office of Medicaid Policy and Planning to share data

and implement initiatives to decrease neonatal mortality.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80.4	81.1	81	78.5	76.6
Annual Indicator	78.5	78.2	77.6	76.5	76.5
Numerator	69054	68723	69358		
Denominator	87961	87864	89404		
Data Source					ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	77.5	78.5	79.5	80.5	81.5

Notes - 2008
Projected figure based on actual previous years and 2007 provisional data from ISDH - ERC.

Source of data: ISDH ERC

Notes - 2007
Provisional calculated based on trend analysis. Program will not allow us to change objective for 2007 or it would have been lowered. Future objectives have been adjusted based on trend analysis; however, we are hoping to reverse the downward trend in the near future based on our programs.

Source of data will be ISDH ERC

Notes - 2006
Actual data final.

Source of data: ISDH ERC.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.3%.

Status: 76.5 % based on 2008 data

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

MCSHC in collaboration with the Indiana Perinatal Network (IPN) and Indiana ACOG completed and published the IPN Prenatal Care Guide (standards) to include preconception/interconception care on the IPN website September 30, 2008.

MCSHC continued to disseminate the Baby First educational materials statewide through the Indiana Family Helpline. Fifteen Baby First educational packets at a time were distributed to prenatal care providers, agencies and one packet was sent to each individual that requested one of packets from the Indiana Family Helpline.

Funding of prenatal care coordination projects throughout the state provide outreach, case finding, referral, advocacy, and education of at risk pregnant women. MCSHC funded 22 PNCC projects in 2008.

County data books, including entrance into prenatal care have been published on the ISDH website and shared with local communities in counties with significant access problems.

Vital Records data on time of entrance into prenatal care was shared with the State Perinatal Advisory Board, was published in a Perinatal Perspectives Newsletter and was shared with counties with access to care problems that will receive technical assistance from MCSHC to identify barriers and plans to improve access.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Funding of prenatal care coordination projects throughout the state will continue to provide outreach, case finding, referral, advocacy, and education of at risk pregnant women.			X	
2. County data books, including entrance into prenatal care continues to be updated as new data is available on the ISDH website and shared with local communities in counties with significant access problems. 2006 data is all that is available.				X
3. Title V funded prenatal and PNCC projects are mandated in 2009 and 2010 to provide neighborhood outreach through the MCH free pregnancy program, enroll women with positive pregnancy tests.				X
4. Vital Records data on time of entrance into prenatal care was shared with the State Perinatal Advisory Board, was published in a Perinatal Perspectives Newsletter and was shared with counties with access to care problems.				X
5. IPN hosted a second “Controversies and Innovations in Perinatal Health”, State Perinatal Forum March 25-26, 2009 with a focus on access to care.				X
6. Implement the Early Start program in at least one of the counties with poor access to prenatal care due to systems barriers.	X			
7. After collaboration of ISDH, IPN, Title X and the Office of Medicaid Policy & Planning (OMPP) decided to reinstate the plan for presumptive eligibility. MCH has been working closely with OMPP on this & PE will go into effect statewide July 1, 2009.				X
8. Target 1 emergency department in 1 Priority County to implement the ER protocol to refer all pregnant women in the ER				X

to PNCC and a MCH funded prenatal clinic or CHC.				
9. MCH is partnering with Indiana March of Dimes, Indiana Perinatal Network, Anthem Healthcare, the Women's Center of Excellence, Purdue University/ISDH Multi-state Learning Collaborative and others to prepare for a Perinatal Initiative summit.				X
10.				

b. Current Activities

b. FY 2009 Current Activities

Funding of prenatal care coordination projects throughout the state provides outreach, case finding, referral, advocacy, and education of at risk pregnant women.

County data books, including entrance into prenatal care continue to be updated as new data is available on the ISDH website and shared with local communities in counties with significant access problems.

Title V funded prenatal and PNCC projects are mandated in 2009 and 2010 to provide neighborhood outreach through the MCH free pregnancy test program, enroll women with positive pregnancy tests, identify another project specific outreach activity, and identify another project activity to increase enrollment in the first trimester. Projects will report results quarterly.

Vital Records data on time of entrance into prenatal care was shared with the State Perinatal Advisory Board, was published in a Perinatal Perspectives Newsletter and was shared with counties with access to care problems that will receive technical assistance from MCSHC to identify barriers and plans to improve access.

IPN hosted a second "Controversies and Innovations in Perinatal Health", State Perinatal Forum March 25-26, 2009 with a focus on access to care. A panel of physicians and hospital administrators looked at the accessibility of prenatal care in rural and non urban counties. Model programs were presented in break out sessions.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

Title V funded prenatal and PNCC projects are mandated in 2009 and 2010 to provide neighborhood outreach through the MCH free pregnancy program, enroll women with positive pregnancy tests, identify another project specific outreach activity, and identify another project activity to increase enrollment in the first trimester. Projects will report results quarterly.

Explore incorporating community based doulas into Healthy Families Indiana to facilitate early identification of repeat pregnancies and assistance and follow-up of mothers through the pregnancy.

Continue work with stakeholders on the MCH Perinatal Initiative, including March of Dimes, Indiana Perinatal Network, INACOG, Indiana State Medical Association, Maternal Fetal Specialist, Anthem, WellPoint, Medicaid, Neonatalogists, Association of Women's Health Obstetric and Neonatal Nurses (AWHON), Indiana Women's Center on Excellence, Indiana Tobacco Prevention Coalition, Indiana Health Association, Title X, Indiana Academy of Family

Practitioners,National Association of County and City Health Officials, Healthy Start, Indiana Minority Health Coalition, Healthy Mothers, Healthy Babies, and the Indiana Rural Health Association.

Work with Purdue University to assess PPOR in 5 counties and present results during county meetings.

D. State Performance Measures

State Performance Measure 1: *The number of data sets, including the NBS, UNHS, Lead, IBDPR, Immunizations, CSHCS, Vital Statistics, and First Steps Data, that are completely integrated into the Indiana Child Health Data Set.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			1	1	1
Annual Indicator		1	2	1	1
Numerator		1	2	1	1
Denominator	1	1	1	1	1
Data Source					ISDH - DISC
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1	1	1	1	1

Notes - 2008
Source of Data: ISDH Data Integration Steering Committee

Notes - 2007
Source of Data: ISDH Data Integration Steering Committee

Notes - 2006
Source of Data: ISDH Data Integration Steering Committee

a. Last Year's Accomplishments
FY 2008 Performance Objective: At least one additional data set will be integrated into the Indiana Child Health Data Set. This was the objective under the old definition. Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data measures will be completely integrated/linked into the Indiana Child Health Data Set, with at least two additional data measures under way in final development and testing.

Status: Met Performance Objective -- integrated one additional data set into the Indiana Child Health Data Set.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

The Indiana Child Health Data Set (ICDS), formerly known as the Operations Data Store (ODS) development team, coordinated by the Data Integration Steering Committee (DISC), continued to develop and test input and output from various sources, most importantly the Vital Records.

Universal Newborn Hearing Screening, Lead, Indiana Birth Defects and Problems Registry,

Immunizations, Children's Special Health Care Services, and First Steps data continued to be developed for integration into the ICDS when completed.

The integration of the EHDI portion of Newborn Screening, and the Indiana Birth Defects and Problems Registry into the Indiana Child Health Data Set for initial use started.

The integration work and testing of First Steps data began.

The use of verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations began.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The integration of the EHDI portion of Newborn Screening, and the Indiana Birth Defects and Problems Registry into the Indiana Child Health Data Set for initial use was completed.				X
2. The integration work and testing of First Steps data began.				X
3. The use of verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations began.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

The integration of the EHDI portion of Newborn Screening, and the Indiana Birth Defects and Problems Registry into the Indiana Child Health Data Set for initial use was completed.

The integration work and testing of First Steps data continues.

The use of verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations continues.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

The Newborn Heel Stick Screening data mart development and implementation will continue.

The Lead program integration/linkage evaluation along with the CHIRP data evaluation for integration/linkage will continue.

The Children's Special Health Care Services and The First Steps data will continue to be intergrated into the Indiana Child Health Data Set.

State Performance Measure 2: *The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0 - 493.9) among children less than five years old.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	73.3	38	29	28	23
Annual Indicator	29.6	28.9	25.0	22.9	20
Numerator	1276	1242	1076		
Denominator	430557	430439	431089		
Data Source					ISDH Asthma Pgm
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	19	18	17	16

Notes - 2008
Projected data based on previous years' data.

Source of data: ISDH Asthma program

Notes - 2007
Minor correction from ISDH Asthma Program (Chronic Disease): Actual data for FY2007 would have been 22.88 per 10,000 children under age 5. 40 children who were not INdiana residents had been previously included in data submitted by the Asthma program.

Source of data will be ISDH Chronic Disease Program

Notes - 2006
Source of data: ISDH Chronic Disease Program

a. Last Year's Accomplishments
FY 2008 Performance Objective: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will drop to 27.0.

Status: The rate per 10,000 for diagnosed asthma hospitalizations among children less than five years old was 20.0 in 2008.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

The Asthma Program worked with the Ad Council and the Indiana State Department of Health's Office of Public Affairs to encourage all radio and TV stations throughout Indiana to play localized National Asthma Campaign PSA's during Asthma Awareness Month (May). The Asthma Program and Indiana Joint Asthma Coalition [InJAC] have also printed educational materials and delivered to libraries, community health centers, Medicaid providers, Head Start programs and rural health clinics in at least 15% of the state's counties. An email was sent in March to school administrators

and other school personnel (statewide) to consider planning an activity for Asthma Awareness Month.

In May 2008, the Asthma Program held a statewide contest to further raise awareness of asthma for Asthma Awareness Month. The contest had an Indianapolis 500 theme and encouraged children to complete activities (coloring, word search, and word scramble based on age) to identify common asthma triggers. Approximately 300 contest entries were received. Contest winners received autographed merchandise from Indy 500 drivers, tickets to the Indy 500 qualifying days, Wal-Mart gift cards, Indianapolis Indians tickets, Children's Museum tickets, and more. The Program also participated in the 500 Festival Kid's Day to reach families during Asthma Awareness Month.

The Asthma Program highlighted the 5-Star Recognition Program for child care settings and data on asthma among children in the Breathe In, Breathe Out newsletter. The 5-Star program helps regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma. The newsletter is available online at http://www.in.gov/isdh/17279.htm.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In April 2009, the Asthma Program (along with the Indiana Joint Asthma Coalition) launched statewide asthma training for child care providers.				X
2. The Asthma Program and InJAC are working with the ISDH's MCH Program to review the medical guidelines for asthma for the Children's Special Health Care Services (CSHCS).				X
3. The Asthma Program is working with the Indiana Tobacco and Prevention and Cessation Head Start Advisory Group on a toolkit to help Head Start centers address children's exposure to environmental tobacco smoke.		X		
4. The Asthma Program received an award from the American Academy of Pediatrics, Richmond Center of Excellence to support a visiting lecturer for two days to address secondhand smoke and children's health.				X
5. The Asthma Program is promoting the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

In April 2009, the Asthma Program (along with the Indiana Joint Asthma Coalition) launched statewide asthma training for child care providers. Asthma training is being provided free of charge to any child care provider in the state requesting the training. Training is delivered by the Child Care Health Consultants within the Bureau of Child Care, Family and Social Services Administration. Participants receive a folder of materials to reinforce training messages, a poster

with steps to take during an asthma emergency, and cleaning spray bottle with messages on how cleaning can remove asthma triggers.

The Asthma Program and InJAC are working with the Indiana State Department of Health Maternal and Child Health Services Program to review the medical guidelines for asthma for the Children's Special Health Care Services (CSHCS).

The Asthma Program is working with the Indiana Tobacco and Prevention and Cessation Head Start Advisory Group on a toolkit to help Head Start centers address children's exposure to environmental tobacco smoke (ETS) and reduce smoking among staff and parents.

The Asthma Program received an award from the American Academy of Pediatrics, to support a visiting lecturer for two days to address secondhand smoke and children's health. On May 20th and 21st, Dr. Jonathan P. Winickoff will present to pediatricians, health leaders and local tobacco coalitions to share methods for reducing children's exposure to secondhand smoke.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

The Asthma Program will continue to promote the asthma training for child care providers developed by the program and InJAC. The Asthma Program will also be responsible for distributing follow-up materials to participants.

The Asthma Program and InJAC will develop online asthma training for child care providers to compliment existing in-person trainings. Upon completion of the online training, participants will receive a folder of materials to reinforce training messages, a poster with steps to take during an asthma emergency, and cleaning spray bottle with messages on how cleaning can remove asthma triggers.

Data from the Children's Call-Back Survey of the Behavioral Risk Factor Surveillance System will be reported. This will be the first time Indiana is able to provide detailed information on asthma among children, such as medication use, environmental exposures, and asthma-related absenteeism.

In Fall 2009, the Asthma Program and InJAC will launch a continuing medical education (CME) online training for health care providers. The training is specific to understanding the key points and key differences of the updated Expert Panel Report: 3 (EPR: 3) Guidelines for the Diagnosis and Management of Asthma.

The Asthma Program and InJAC will provide information to participating providers in the CSHCS program to ensure their awareness of the key points and key differences in Expert Panel Report:3 (EPR:3) Guidelines for the Diagnosis and Management of Asthma.

The Asthma Program will promote the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma. The State Asthma Program will also dedicate one staff to participate on the review committee for the 5-Star Recognition Program.

State Performance Measure 3: *The percent of live births to mothers who smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	19.5	17.8	17.1	16.5	16
Annual Indicator	17.9	17.7	17.3	17.1	16.9
Numerator	15707	15589	15450		
Denominator	87961	87864	89404		
Data Source					ISDH - ERC
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16.7	16.5	16.3	16.1	15.9

Notes - 2008
Projected data.

Source of data will be ISDH Epidemiology Resouce Center. Data for CY2007 based on trend analysis.

Application would not allow a change in 2008 objective. However, actual 2008 objective would have been 16.8.

Notes - 2007
Source of data will be ISDH Epidemiology Resouce Center. Data for CY2007 based on trend analysis.

Application would not allow a change in 2007 objective. However, actual 2007 objective will be 17.1.

Notes - 2006
Source of data ISDH Epidemiology Resouce Center. Data for CY2006.

a. Last Year's Accomplishments
FY 2008 Performance Objective: The percent of live births to mothers who smoke will decrease to 16.0% in CY 2008.

Status: 16.9% in 2008 ** The Indiana birth certificate was changed in 2007 to conform to new national standards in the US Birth Certificate set in 2003. This affected many variables, including maternal smoking. The data, therefore, may not be strictly comparable to data of prior years.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

ISDH continued to facilitate a legislative commission on prenatal smoking, alcohol, and drug use to develop a strategic plan. Meetings were held bi-monthly. An interim report was submitted to the legislature in August 2008. Efforts are ongoing to pursue funding and implementation of the recommendations.

The ISDH Prenatal Substance Use Prevention Program (PSUPP) screened 4,850 pregnant women, identifying the high risk, chemically dependent, and providing counseling and intervention/referral. They also began collaborating with Indiana Access to Recovery (ATR), a program that assists substance users in getting the professional help needed to quit. Pregnant women are one of their target groups.

PSUPP/MCSHC continued their collaboration with ITPC to have greater impact on smoking cessation with pregnant women. The Indiana Tobacco Quit Line expanded its follow-up program for pregnant women who now receive ten calls instead of five.

PSUPP, and all MCSHCS-funded prenatal clinics, incorporate education of women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy. PSUPP gave 574 educational talks for providers and the public and participated in 134 community/health fairs and conferences in their communities.

A training of physician representatives of all 3 MCO's on smoking cessation, evidence based assessment tools, the 5A's, 5R's and the Indiana Tobacco Quitline was completed in the Spring by Clarian Tobacco Control Center, a member of the Indiana Coalition to Prevent Smoking in Pregnancy (CPSP).

All ITPC County Coalitions have been trained in the ACOG prenatal provider office training model and are replicating the in-office training in 80 counties. These community-based networks are also implementing strategies based on the Clinical Practice Guideline for Treating Tobacco Use and Dependence, such as establishing cessation networks and changing policies throughout the community.

MCSHC worked with Indiana Perinatal Network (IPN) and IN ACOG to disseminate information on prenatal smoking cessation. On 3/20/2008, a Smoking Cessation Panel Discussion was conducted at the IPN State Forum: Controversies and Innovations in Perinatal Health. 120 persons attended the Forum.

MCSHC informed all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW, and Quitline materials promoting the Quit Line were made available to all funded prenatal projects

MCSHC continued to participate on the OMPP Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients to decrease NICU admissions due to complications from prenatal smoking. Each MCO was expected to refer pregnant women to the Indiana tobacco Quitline and each MCO developed a smoking cessation program.

MCSHC continued as a partner in the Coalition to Promote Smokefree Pregnancies with ITPC, Clarian, American Lung Association, and other agency members. The coalition collaborated to write a grant to ITPC to provide media campaigns targeted to women of child bearing age in all counties with a prenatal smoking rate of >29. The grant was awarded July 1, 2008. Clarian Tobacco Control Center is serving as the fiscal agent for the grant.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. ISDH continues to facilitate the legislative PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan.				X
2. All MCSHC Title V funded prenatal services are mandated to address Federal Performance Measure 8.				X
3. A prenatal smoking cessation training webinar on assessment and brief intervention has been completed (April, 2009) and placed on the MCH website.				X
4. MCSHC will analyze the rate of smoking in the third trimester				X

on a quarterly basis to determine further training needs.				
5. The ISDH Prenatal Substance Use Prevention Program (PSUPP) continues to identify high risk, chemically dependent pregnant women and provide counseling and intervention.	X			
6. PSUPP continues to participate in (134) community events, health fairs, conferences, and other public forums.	X			
7. PSUPP continues to distribute 28,000 informational items about the impact of substance use on pregnant women to the public.			X	
8. PSUPP continues to distribute 6,500 educational items to providers, including physician's offices, indicating the importance of identifying at-risk clients.			X	
9. PSUPP clinics (3) in Terre Haute, Evanville and Jeffersonville continue to provide support groups for women in substance use cessation.	X			
10. MCH continues to participate on the Office of Medicaid Policy and Planning (OMPP) Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients.				X

b. Current Activities

b. FY 2009 Current Activities

ISDH continues to facilitate the legislative PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan. Dr. Nocon the Commission Chair presented information on assessment and brief intervention in pregnant women at the Indiana ACOG conference 3/09.

All MCSHC Title V funded prenatal services are mandated to address Federal Performance Measure 8.

A prenatal smoking cessation training webinar on assessment and brief intervention has been completed (April, 2009) and placed on the MCH website. All funded prenatal projects must access the webinar and complete the pre-post test by August 31, 2009.

MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine further training needs.

The ISDH Prenatal Substance Use Prevention Program (PSUPP) continues to identify high risk, chemically dependent pregnant women and provide counseling and intervention.

PSUPP continues to: participate in (134) community events, health fairs, conferences, and other public forums, distribute 28,000 informational items about the impact of substance use on pregnant women to the public, distribute 6,500 educational items to providers, including physician's offices, indicating the importance of identifying at-risk clients, and provide support groups for women in substance use cessation.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

Baby First Packets, that includes information on smoking cessation, will be sent to Prenatal IFHL

callers.

MCH will continue to participate in the Coalition to Prevent Smoking in Pregnancy to reach out to health care providers and women of childbearing age in counties with high smoking rates to decrease prematurity, low birthweight, and exposure to second smoke among infants and children.

MCH will analyze prenatal smoking data through monthly data from the Notification of Pregnancy form and cessation outcomes of the new Prenatal Care Coordination program, Indiana Healthy Beginnings for success and training needs.

MCH will continue to work with the Office of Medicaid Policy and Planning and the Medicaid Managed Care Organizations to decrease smoking among pregnant women on Medicaid.

MCH will continue to work with the Indiana Perinatal Network to provide prenatal smoking education to prenatal health care providers through forums and newsletters.

The PSUPP program will continue to collaborate with ATR to refer pregnant substance-using women to providers for needed services.

The Provider Resource List will be maintained and updated for public use.

State Performance Measure 4: *The percent of black women (15 through 44) with a live birth whose prenatal care visits were adequate.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	67	62	63	64	59
Annual Indicator	61.3	60	57.3	58	58
Numerator			5957		
Denominator			10396		
Data Source					ISDH - ERC
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	59	60	61	62	63

Notes - 2008
IProjection based on trend analysis. Data for FY2008 not available.

Application would not allow change of 2008 objective. Actual 2008 objective would be 58.

Notes - 2007
Indicator will be provided by Epidemiology Resource Center. Data provided for FY2007 based on trend analysis.

Application would not allow change of 2007 objective. Actual 2007 objective will be 58.

Notes - 2006
Indicator provided by Epidemiology Resource Center. Denominator provided by ERC also. Numerator calculated.

a. Last Year's Accomplishments

FY 2008 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 65% in FY 2008.

Status: 58% for 2008

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

MCSHC provided ongoing technical assistance to Allen, Elkhart, Lake, LaPorte, Marion, and St. Joseph counties to strengthen community partnerships between policymakers, health care providers, families, the general public, and others to form county coalitions to identify and solve perinatal disparity issues through coalition meetings, conference calls, and e-mails.

ISDH provided at least yearly training to county perinatal disparity coalitions on cultural competency, social determinants in perinatal disparities, life course perspective, impact on perinatal care, how to use tools to create and implement local action plans, and exploring promising approaches for effective action. Perinatal Summit held in Lake County, Presented GIS maps and information on social determinates in St. Joseph County and Allen County, Presentation to Marion County Healthy Babies Coalition on Life Course and social determinates, met with LaPorte County and Elkhart County Health Officer and staff on their perinatal outcomes and best practice models to address outcomes in their county.

MCSHC continued to meet monthly with the Hoosier Healthwise Quality Improvement Committee, and work with OMPP through the Quality Strategy Prenatal Workgroup to reduce disparity issues in prenatal care through accessible early entry into prenatal care.

Information on Community Based Doulas, Centering pregnancy, Baby First Advocates, Faith based mentoring programs, and How to Have a Healthy Baby was shared with all targeted counties and can be found on the Indiana Perinatal Network at indianaperinatal.org

The "A Healthy Baby Begins with You" media campaign was implemented in Marion, Lake, St. Joseph, and Vanderburgh Counties as well as at Black Expo.

IPN and MCSHC addressed perinatal disparities by sponsoring a booth at the Indiana Black Expo Black and Minority Health Fair in July, 08.

Indiana School of Nursing is providing ongoing evaluation of the community based Doula program. MCSHC will assess the feasibility of replication based on outcomes and cost. Outcomes so far look promising. Additional funding will be sought to replicate the project.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. To increase the percent of black women with adequate prenatal care in 2009, prenatal projects applying for Title V funding for 2009 and 2010 were mandated to increase the number of black women entering prenatal care in the 1st trimester.				X
2. The Office of Minority Health media campaign A Healthy Baby Begins with You will continue to be implemented in the disparity counties as well as at Black Expo.			X	

3. FIMR will continue in three Indiana Counties with a focus on disparity deaths. The FIMR in St. Joseph County was not refunded due to lack of funds and ongoing turnover of staff.	X			
4. MCH presented Unnatural Causes videos and disparity information during “Lunch and Learns” every Wednesday in September.			X	
5. Three Indiana Counties have 2006 Black infant mortality rates over 30/1,000 (St. Joseph, Allen, Delaware). MCSHC has presented an analysis of birth outcomes and infants deaths in each county.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
b. FY 2009 Current Activities

Prenatal projects applying for Title V funding for 2009 and 2010 were mandated to: 1) increase the number of black women entering prenatal care in the 1st trimester through a community/neighborhood outreach plan to include African American churches, 2) provide reminder/recalls for all scheduled appointments for black pregnant women, 3) identify and refer all high risk pregnant women to an appropriate high-risk provider and to prenatal care coordination. Projects will be monitored and technical assistance will be given those projects in need.

The Office of Minority Health media campaign, "A Healthy Baby Begins with You", will continue to be implemented in the disparity counties as well as at Black Expo, which attracts 300,000 visitors each year.

FIMR will continue in three Indiana Counties with a focus on disparity deaths. The FIMR in St. Joseph County was not refunded due to lack of funds and ongoing turnover of staff.

MCH presented "Unnatural Causes" videos and disparity information during "Lunch and Learns" every Wednesday in September.

Three Indiana Counties have 2006 Black infant mortality rates over 30/1,000 (St. Joseph, Allen, Delaware). MCSHC has presented an analysis of birth outcomes and infants deaths in each county and will continue to work with county coalitions and county minority coalitions to address these third world statistics.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

Three Indiana Counties have Black infant mortality rates over 30/1,000 (St. Joseph, Allen, Delaware). MCSHC has presented an analysis of birth outcomes and infants deaths in each county and will continue to work with county coalitions and county minority coalitions to address these third world statistics.

The Office of Minority Health media campaign, " A Healthy Baby Begins with You", will continue

to be implemented in the disparity counties as well as at Black Expo.

Collaborate with Minority Health Coalitions in St. Joseph, Allen, Marion, Delaware, Lake, and Vanderburgh Counties to conduct a series of community conversations in Black neighborhoods to show the unnatural causes videos, provide education and empower residents to plan neighborhood activities.

Work with hospitals to show the "Unnatural Causes" videos and life course perspective at grand rounds.

State Performance Measure 5: *The percentage of children age 0 to 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			2.4	2.4	0.8
Annual Indicator		2.5	1.0	0.8	0.8
Numerator			637	573	
Denominator			61650	72798	
Data Source					ISDH - LEAD
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0.7	0.6	0.6	0.5	0.5

Notes - 2008
Projection made based on previous years' data.

Source of data: ISDH LEAD program.

Notes - 2007
Source of data: ISDH LEAD Program. Now that the new software is completely installed and running, the improvement was dramatic. The application will not allow for changes to objectives in 2006-2007, but the actual figures were much smaller. This trend we hope to continue. 2007 figure is provisional based on the new baseline figure (2006's actual). Objectives revised to reflect this as well.

2007 objective will be .9.

Notes - 2006
Source of data: ISDH LEAD Program. Now that the new software is completely installed and running, the improvement was dramatic. The application will not allow for changes to objectives in 2006-2007, but the actual figures were much smaller. This trend we hope to continue. 2007 figure is provisional based on the new baseline figure (2006's actual). Objectives revised to reflect this as well. 2006 objective would have bveen 1.0.

a. Last Year's Accomplishments
FY 2008 Performance Objective: During FY 2008 the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will be maintained at 1.6%.

Status: Met Performance Objective - In FY 2008, 77,408 children were tested. Of the children tested, 636 had a confirmed elevated blood lead level equal to or greater than ten (10)

micrograms per deciliter of blood. The percentage of confirmed elevated children was .82%.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

Training was conducted on the administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING. Over 325 people were trained through twenty-seven (27) training sessions. These training sessions included regional trainings, one on one training with local health department staff and the annual Indiana Lead-Safe and Healthy Homes Conference.

The Indiana Lead and Healthy Homes Program held its annual training to assist local entities in applying for HUD lead hazard control grant funds on March 18, 2008. Thirty-nine individuals representing communities from all over the State attended.

One new HUD grant totalling approximately three million dollars was awarded in Indiana's Marion County in the fall of 2007.

The Program changed its name to the Indiana Lead and Healthy Homes Program (ILHHP) to more accurately reflect the mission of the program.

ILHHP established a Memorandum of Understanding with the Indiana Department of Environmental Management (IDEM) to administer the Lead-Based Paint regulations (326 IAC 29), including: abatement notification, training provider accreditation, monitoring and lead professional licensing. Concurrently, IHLLP was awarded EPA grant funds for the purpose of the program which is assisting in efforts in the primary prevention of lead poisoning among children.

The Attorney General, State Health Commissioner and the Indiana General Assembly worked together to create and pass comprehensive lead legislation (SEA 143). This legislation addressed lead in consumer products, training of retail employees selling paint or painting products, and laboratories not reporting complete and accurate information on children being tested for lead poisoning.

ILHHP increased efforts to improve the screening rate of Medicaid recipient children. Information on MCO screening rates is made available in a formal data exchange between ILHHP and Medicaid. Contract incentives were added for MCOs to improve screening rates. MCOs implemented contracts for filter paper testing.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. ILHHP continues efforts to improve the screening rate of Medicaid recipient children. Information on MCO screening rates is made available in a formal data exchange between ILHHP and Medicaid.				X
2. ILHHP will work to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: .				X
3. Eight local health departments will be Medicaid providers and will be actively seeking reimbursement for all lead related services.	X			

4. ILHHP will continue to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.	X			
5. ILHHP will decrease the percent of elevated children through increased primary prevention activities including increasing the overall number of environmental inspections and investigations.	X			
6. ILHHP will increase awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.			X	
7. Six million dollars was awarded to two local health departments in Indiana to address lead hazards through President Obama's American Recovery Act of 2009.				X
8. Legislation to transfer the Lead-Based Paint Program from the Indiana Department of Environmental Management to the Indiana State Department of Health was introduced in the 2009 General Assembly session.				X
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

ILHHP continues efforts to improve the screening rate of Medicaid recipient children. Information on MCO screening rates is made available in a formal data exchange between ILHHP and Medicaid.

410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING will be revised to reflect current recommendations from the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) and changes due to SEA 143.

ILHHP is working to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.

Eight local health departments are Medicaid providers and will be actively seeking reimbursement for all lead related services.

ILHHP continues to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.

ILHHP is increasing awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.

Six million dollars was awarded to City of Gary Health Department and the Elkhart County Health Department in Indiana to address lead hazards through President Obama's American Recovery Act of 2009.

c. Plan for the Coming Year
c. FY 2010 Planned Activities

Training will be conducted on the revised administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING. These training sessions will include regional trainings, one on one training with local health department staff and the annual Indiana Lead-Safe and Healthy Homes Conference.

ILHHP will work to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.

ILHHP will work with the Indiana Lead-Safe Housing Advisory Council and the Indiana General Assembly to introduce comprehensive lead legislation focusing on retaliatory evictions for contacting local health departments and issues surrounding lead hazards in rental property.

ILHHP will work to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.

ILHHP will decrease the percent of children with elevated blood lead levels through increased primary prevention activities including: increasing the overall number of environmental inspections and investigations, increasing the number of housing units becoming lead safe by increasing follow-up and enforcement of existing regulations, helping to increase the lead hazard remediation grants in the state, improving training and increasing the number of licensed lead professionals, improving enforcement of existing abatement regulations, and an expanded mission to include an overall healthy homes approach to environmental case management.

ILHHP will continue in efforts to affect an increase in the percent of Medicaid screened children by encouraging Medicaid reimbursement for testing, case management, and environmental inspection.

ILHHP will improve lead program data collection and analysis including: data collections and comparisons with other programs such as Medicaid and WIC, use of the I-LEAD web application to produce consistent and effective risk assessments and environmental follow-up, development of an enhanced database of medical and case management information.

ILHHP will increase awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.

State Performance Measure 6: *The proportion of births occurring within 18 months of a previous birth to the same birth mother.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			18	17	16
Annual Indicator		18.4	11.9	17	16
Numerator					
Denominator					
Data Source					ISDH ERC
Is the Data Provisional or Final?				Provisional	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	15	14	14	13	12

Notes - 2008
Am attempting to get this data from ISDH ERC.

Notes - 2007
FY 2007 Data Unavailable. Indicator has been entered to reflect expected objective. Real objective will be maintained at 17, as 11.9 could be an outlier. Figure is inconsistant; no trend analysis possible yet. Source of Data will be ISDH HSC Program.

Notes - 2006
FY2006 data unavailable; baseline continued.

a. Last Year's Accomplishments
FY 2008 Performance Measure: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 17%.

Status: In 2007, 17% of mothers had a birth that was within 18 months of previous birth. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

MCSHC staff, IPN, March of Dimes, Title X and other members of the Unintended Pregnancy committee are working with DOE to add sexuality and pregnancy prevention to the curriculum of junior high school students. The adolescent coordinator has been working with DOE to implement a curriculum. The Indiana RESPECT program continues to do a statewide media campaign and funds abstinence and pregnancy prevention programs in schools and in communities.

A birth cohort data analysis was utilized to identify commonalities in the subpopulation of women who do not space births at least 18 months. It was completed January 2008 and is on the ISDH website. In general, mothers with short interpregnancy interval were more likely to be black, Hispanic, under 25 years of age, less educated, unmarried, of higher parity, smoker, and receiving inadequate or no prenatal care compared to mothers with longer interpregnancy interval. Controlling for these potential confounding variables, interpregnancy interval of less than 6 months and up to 12 months was associated with significantly higher risks of low birth weight, preterm, and small-for gestational age births.

IPN hosted "Controversies and Innovations in Perinatal Health", a State Perinatal Forum March 19, 2008 with a focus on Unintentional Pregnancy and birth spacing.

Interconception messages were published in one Perinatal Perspectives newsletter, and placed on the web.

Indiana ACOG and Indiana AAP endorsed the consensus statement: "Best Intentions: Unplanned Pregnancies and the Well-being of Indiana Families". MCH perinatal consultant provided training to Family Practice residents taking their public health rotation at ISDH on the life course perspective fetal origins of chronic disease and why they need to "ask every woman every time" about a life plan, and interconception health, regardless of whether they are seeing the child or the mother for a routine preventative exam.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop media messages that address interpregnancy intervals. Consultants from Title X have met with coalitions in disparity counties about developing a county level program.				X
2. Work with the ISDH Office of Women's Health, to develop an "Every Woman, Every Time" movement with provider trainings, consumer media and marketing.				X
3. IPN hosted a second "Controversies and Innovations in Perinatal Health", State Perinatal Forum March 25-26, 2009 with a focus on access to care.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

Consultants from Title X have met with coalitions in disparity counties about developing a county level media program to address interpregnancy intervals.

MCH is working with the ISDH Office of Women's Health, the Indiana Office of Medicaid Policy and Planning, Indiana Perinatal Network and the Indianapolis Women's Center of Excellence to develop an "Every Woman, Every Time" movement with provider trainings, consumer media and marketing.

IPN hosted a second "Controversies and Innovations in Perinatal Health", State Perinatal Forum March 25-26, 2009 with a focus on access to care. Unintended pregnancies were discussed.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

IPN will work with state stakeholders to implement two (2) of the recommendations in the consensus document, Best Intentions: Unplanned Pregnancy.

Continue to work with the ISDH Office of Women's Health, the Indiana Office of Medicaid Policy and Planning, Indiana Perinatal Network and the Indiana University School of Medicine Women's Center of Excellence to develop an "Every Woman, Every Time" movement with provider trainings, consumer media and marketing

MCSHC and the State Perinatal Advisory Board and others will explore the best way to operationalize the concept of interconception care for health care providers and will implement at least one strategy (e.g., vitamins for the whole family- all family members take a Flintstone vitamin together -- to promote healthy families and folic acid for women., Rx pads for physicians to give all to women of childbearing age in their practice with "Every Woman, Every Time" messages.)

State Performance Measure 7: *Number of community/neighborhood partnerships begun in 5 targeted counties to identify perinatal disparities.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			1	1	1
Annual Indicator		1	1	1	1
Numerator		1	1	1	1
Denominator	1	1	1	1	1
Data Source					HSD SME
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1	1	1	1	1

Notes - 2008
Targeted counties are Allen, Elkhart, Lake, Marion, and St. Joseph. Per Beth Johnson, ISDH Health Systems Development Consultant working closely on this goal, we are achieving success in establishing partnerships with at least one community/neighborhood site in each of the targeted counties per year. The goal is eventually to have 5 community/neighborhood sites partnering in each of the five counties to identify and address perinatal disparities.

Notes - 2007
Targeted counties are Allen, Elkhart, Lake, Marion, and St. Joseph. Per Beth Johnson, ISDH Health Systems Development Consultant working closely on this goal, we are achieving success in establishing partnerships with at least one community/neighborhood site in each of the targeted counties per year. The goal is eventually to have 5 community/neighborhood sites partnering in each of the five counties to identify and address perinatal disparities.

a. Last Year's Accomplishments
FY 2008 Performance Measure Objective: The number of targeted communities with such community/ neighborhood partnerships will increase from 2 to 3 in 2008.

Status: Met - Increased by 1 (one) in 2008

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

Lake County had another perinatal disparity summit in February and formed a disparity coalition consisting of Hospital CEOs, physicians, health and human service providers in Lake and Porter County. The Lake County MCH Network continued to put plans into action and developed a resource guide for ER physicians seeing minority pregnant women.

Three meetings with the St. Joseph Healthy Babies Coalition occurred. GIS maps and new data were shared. Three funded Prenatal Care Coordination projects in South Bend were asked to cover the census tracts identified as highest risk for preterm, low birthweight, and infant mortality. One zip code in the southern part of the county was not receiving services but had problems with smoking, low birthweight and infant mortality. As a result of the data sharing one of the PNCC teams began providing services to the southern zip code. Programs to outreach to Black pregnant women, and educational/support groups for Black women were planned.

Marion County Healthy Babies Coalition members were presented with FIMR data, PPOR data, and Vital Records data and identified preconception and interconception programs as the top priorities.

The Indiana State Plan on Perinatal Disparities is still in progress. All counties have not completed a disparity plan.

A statewide summit on the Life Course Perspective and Black perinatal disparities was held September 17th, 2008 in Hammond. Dr. Collins from Chicago and Mario Drummond from the Harlem Project were the main speakers.

MCSHC began working with OMPP and Indiana Family Health Council (Title X), and IPN on a presumptive eligibility (PE) plan to be implemented in early 2008, and a state family planning waiver. In April, 2008 OMPP announced the Presumptive Eligibility plan was cancelled due to implementation barriers. IPN, ISDH, and other partners continued to work with OMPP to show them how the (PE) initiative could be implemented and the state plan was reactivated.

During the month of September (Infant Mortality Month), a series of Lunch and Learns were presented to staff at ISDH on the Life Course Perspective, Black Perinatal Disparities, and the Perinatal State Plan. "Unnatural Causes" videos were shown over a four week period with discussion following each video. County Coalitions were sent Federal Office of Minority Health "A Healthy Baby is Worth the Wait" educational materials to share in their counties. Talks began with March of Dimes to purchase more "Unnatural Causes" videos for the 17 counties with minority health coalitions to show in their counties during community conversations. ISDH does not have the funds to buy the videos.

MCSHC and ISDH Office of Minority Health (OMH) worked collaboratively to bring the national office of Minority Health media campaign "A Healthy Baby Begins with You" to 3 of the 5 disparity counties (Lake, Marion, St. Joseph, and Vanderburgh) in Indiana as part of the National Partnership for Action to End Health Disparities. MCH had a booth at Indiana Black Expo which included infant mortality disparity information.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Delaware County has been added as the fourth disparity county with a Black infant mortality rate of 32. MCH consultant has attended two TA meetings in February and April to share data and GIS maps and assist in planning.				X
2. MCSHC and ISDH Office of Minority Health (OMH) will work collaboratively to bring the national office of Minority Health media campaign “A Healthy Baby Begins with You” in 3 of the 5 disparity counties.			X	
3. Include infant mortality disparity issues as a part of the Indiana Black Expo.			X	
4. Include required disparity outreach activities for all applicants of the Title V 2009-2010 MCSHC RFP. Promote collaboration with local minority health coalitions and churches.				X
5. MCSHC will continue to provide technical assistance and follow-up to the five targeted disparity counties to help county coalitions address disparity issues.				X

6. Provide 5 perinatal trainings on at least 6 topics for a total of 25 trainings in disparity and focus counties.				X
7. Increase outreach among priority counties to bring in new IPN members, form/expand local perinatal networks/coalitions to utilize current infrastructure in improving perinatal outcomes.				X
8.				
9.				
10.				

b. Current Activities

b. FY 2009 Current Activities

Delaware County has been added as the fourth disparity county with a Black infant mortality rate of 32. MCH consultant has attended two TA meetings in February and April to share data and GIS maps and assist in planning.

The "Healthy Baby Begins with You" materials were disseminated to St. Joseph, Lake, Marion and Vanderburgh counties.

The focus of this year's MCH booth at Black Expo is Children with Special Health Care Needs, with some disparity information available to distribute.

MCH Consultant has attended coalition meetings in Lake, Marion, St. Joseph and Delaware counties to share updated data and state plans. MCH and Purdue will complete a PPOR analysis in the fourth quarter in St. Joseph, Allen and Elkhart counties to further define areas of need.

Provide 5 perinatal trainings on at least 6 topics for a total of 25 trainings in disparity and focus counties.

Increase outreach among priority counties to bring in new IPN members, form/expand local perinatal networks/coalitions to utilize current infrastructure in improving perinatal outcomes. Explore use of videoconferencing to include more members in quarterly State Perinatal Advisory Board Meetings.

To increase the percent of black women with adequate prenatal care in 2009, prenatal projects applying for Title V funding for 2009 and 2010 are mandated to increase the number of black women entering prenatal care in the 1st trimester through a community/neighborhood outreach plan.

c. Plan for the Coming Year

c. FY 2010 Planned Activities

Collaborate with local minority health coalitions in the targeted counties to facilitate community conversations in which Unnatural Causes videos are shown and discussed. This will serve as a beginning of neighborhood empowerment and action.

Share PPOR results with St. Joseph, Allen and Elkhart counties and use to spearhead action on disparity plans.

Show "Unnatural Causes" videos during hospital grand rounds at interested hospitals.

Collaborate with Purdue University to implement the Multi-State Learning Collaborative process in identified disparity counties.

State Performance Measure 8: *The percentage of high school students who are overweight or at risk.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			24.9	24.1	28
Annual Indicator		25.7	25.7	29.1	29.1
Numerator					
Denominator					
Data Source					YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28.5	27	24.5	22	19.5

Notes - 2008
Program would not allow changing 2008 objective or it would have been changed to 29.1, as the YRBS is only conducted every other year.

Source of Data: ISDH YRBS Program.

Notes - 2007
Source of Data: ISDH YRBS Program.

Future objectives adjusted based on 2007 information provided.

Notes - 2006
Source of data will be ISDH YRBS Program. FY2006 data unavailable at present. Data expected to be available prior to end of calendar year. Baseline figure used as projection for FY2006.

a. Last Year's Accomplishments
a. FY 2008 Accomplishments

FY 2008 Performance Objective: The percentage of high school students who are overweight or at risk will decrease by 3% (from the 2007 Youth Risk Behavior Surveillance (YRBS) baseline of 13.8% overweight and 15.3% at risk of overweight) over the next five years.

Status: 29.1% based on 2008 YRBS data.

Activities that impacted this Performance Objective included:

MCSHC funded Bowen Research Center to develop two resource guides to assist with statewide obesity prevention efforts. The first guide identified existing data from several different sources such as the Behavioral Risk Factor Surveillance System (BRFSS) and the YRBS. The second guide featured needs assessment methods that could be implemented by communities to inform the development of community level obesity prevention programs.

Presentations on this material were made on the following dates: 12/7/07, 2/1/08, 3/19/08, 4/1/08 and 4/9/08. In addition to MCH management staff and other high level ISDH program directors; this information was shared with medical residents and key partners and stakeholders at the Indiana Perinatal Network Annual Meeting.

A registered dietitian for the Community Nutrition and Obesity Prevention Division (the former name of the Division of Nutrition and Physical Activity [DNPA]) was hired in September 2007 to lead the state in its efforts to promote fruit and vegetable consumption. Indiana became licensed to use the Fruit & Veggies--More Matters logo in February 2008. Due to a focus on compiling a draft obesity prevention plan and the subsequent management transitions within the division, outlined activities such as providing training the trainer sessions, developing an educational tool kit and releasing an email campaign to all MCH clinics were not completed. New direction for the program was developed in 2008-2009 FY.

School height and weight collection guidelines were distributed through the Indiana Department of Education in the Coordinated School Health newsletter called Healthy Connections. Food demonstrations through the INDY COOKS program were not held.

MCSHC funded the Body Talk program developed and implemented by the Ruth Lilly Health Education Center. The program is designed to increase middle school student's awareness of nutrition, physical activity and body image.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The DNPA has formed a statewide task force of obesity prevention partners as part of the Indiana Healthy Weight Initiative.				X
2. At the first DNPA meeting 50 + task force members learned the rationale behind and the importance of addressing six priority target areas for obesity prevention.				X
3. Two more DNPA full task force meetings and multiple workgroup meetings will be held during fiscal year 2009.				X
4. MCH and the Coalition to Improve Adolescent Health are completing a state plan for addressing adolescent health issues.				X
5. ISDH supported a legislative proposal brought before the Indiana General Assembly that would require school-based BMI collection in grades 3, 5, and 7.				X
6. The DNPA is partnering Covering Kids & Families, Inc. of Indiana and the Indiana School Health Network to finalize a contract that will provide one full-time staff person dedicated to assisting schools in complying with state and federal mandates.	X			
7. DNPA and Ind. Dept. of ED have continued to provide support and assistance for the implementation of the Coordinated School Health Model through a training program called MICHIANA II.				X
8. DNPA has encouraged schools and communities to implement the We Can! ™ Program. We Can!™, is a national program designed to help children maintain a healthy weight by practicing three important behaviors.	X			
9.				
10.				

b. Current Activities

b. FY2009 Current Activities

The DNPA has formed a statewide task force of obesity prevention partners as part of the Indiana Healthy Weight Initiative. As of May 8, 2009, the DNPA held two meetings with the Indiana Healthy Weight Initiative Task Force. Two more full task force meetings and multiple workgroup meetings will be held during fiscal year 2009.

Obesity prevention is included in the Indiana Adolescent Health plan published in May, 2009.

ISDH supported a legislative proposal brought before the Indiana General Assembly that would require school-based BMI collection in grades 3, 5, and 7.

The DNPA has continued to support the expansion of coordinated school health programs.

DNPA has collaborated with the Indiana Department of Education (IDOE). Representatives from IDOE have participated in the Indiana Healthy Weight Initiative Task Force.

DNPA has encouraged schools and communities to implement the We Can! ™ Program. We Can!™, or "Ways to Enhance Children's Activity & Nutrition", is a national program designed to help children maintain a healthy weight by practicing three important behaviors: improved food choices, increased physical activity and reduced screen time. Additional information about this program can be found at www.nhlbi.nih.gov/health/public/heart/obesity/wecan.

c. Plan for the Coming Year

c. FY2010 Planned Activities

The Indiana Healthy Weight Initiative Task Force and the DNPA will continue to develop a state plan for obesity prevention that addresses issues related to childcare and school settings and to specific populations, including childbearing women.

By the end of June 2010, the Indiana Healthy Weight Initiative and the DNPA will complete, publish, and disseminate a state plan for obesity prevention.

In addition to completing the state plan by June 2010, the Indiana Healthy Weight Initiative and the DNPA will complete related implementation, evaluation, and marketing plans.

DNPA and MCH will work together to administer the YRBS. The sample of high schools will be drawn in summer 2009, but surveys will not actually be administered until fall 2009. Once the data are returned to ISDH, the two divisions will work together to disseminate the data and promote policies and programs based on the results.

DNPA, MCH, and the Indiana Healthy Weight Initiative Task Force will investigate strategies for using the MCH adolescent clinics as a pilot setting for obesity prevention interventions.

E. Health Status Indicators

Introduction

Indiana has continued to submit the Health Status Indicators annually. Hoosiers or anyone else can access these statistics included in the grant from the ISDH website. Some of these same data are also found on the website in the statistics that the ISDH Epidemiology Research Center provides. Hoosiers may access whichever data is most user-friendly.

Several of the Health Status Indicators--like the population demographics and the injury and STD statistics--were used as issue benchmarks to determine which counties in Indiana were in highest need of attention both for benchmark issues and overall. From this analysis for all Indiana counties, 30 focus counties were identified along with the issues that needed addressing within those counties. This analysis was included in the criteria for local funding in the MCSHC FY 2007-08 Request for Proposals./2009/ The 30 focus counties identified, along with the issues that need to be addressed within those counties in 2007, continued to be monitored for analysis of progress on Health Status Indicators. //2009//

/2010/ The indicators (see 2009 above) continue to be used as a monitoring tool, particularly for issues where others in ISDH or other agencies are taking the lead, (e.g. injury prevention and STDs), and also at times for evaluation.//2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	6.6	8.3	8.2	8.1	8
Numerator	5781	7249	7334	7277	
Denominator	87124	87088	89404	89835	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

FY2008 data not yet available. Estimate provided based on trend analysis.

Notes - 2007

FY2007 data not yet available. Estimate provided based on trend analysis.

Notes - 2006

Source of data: ISDH ERC.

Narrative:

These indicators will continue to be used as a monitoring tool, particularly for issues where others in ISDH or other agencies are taking the lead, (e.g. injury prevention and STDs). When appropriate, the statistics can also be used for evaluation.

Health Status Indicators 1A, 1B, 2A, and 2B -- low weight births, low weight singleton births, very low weight births, and very low weight singleton births -- directly provide information on that segment of Indiana's population. This supports a focus specifically on efforts to improve factors that contribute to low and very low birth weight babies, e.g., early entrance into prenatal care,

nutritional education guidance, etc. By having several years' data on these measures, it serves as a monitoring tool for our programs and allows us to evaluate the success of the programs involved. At present, despite very small numbers, the multi-year trend is overall trending down or stabilized.

/2009/ In 2009 we will complete a detailed, year-long statistical analysis comparing various cohorts of the mother with various results of births. This will be used in a number of ways, but the one most corresponding to HSI's 1A-2B is specifically the group of cohorts statistically significantly affecting, positively or negatively, the birth weight of the babies. //2009//

/2010/ ISDH completed the detailed statistical analysis comparing various cohorts (see 2009, above). The analysis of this year-long study is currently in process.//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.2	6.5	6.5	6.4	6.3
Numerator	5243	5464	5639	5749	
Denominator	84124	84064	86467	89835	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis.

Notes - 2006
Source of data: ISDH ERC.

Narrative:
These indicators will continue to be used as a monitoring tool, particularly for issues that others in ISDH or other agencies are taking the lead, (e.g. injury prevention and STDs). When appropriate, the statistics can also be used for evaluation.

Health Status Indicators 1A, 1B, 2A, and 2B -- low weight births, low weight singleton births, very low weight births, and very low weight singleton births -- directly provide information on that segment of Indiana's population. This supports a focus specifically on efforts to improve factors that contribute to low and very low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on these measures it serves as a monitoring tool for our programs, and allows us to evaluate the success of the programs involved. At present, despite very small numbers, the multi-year trend is overall trending down or stabilized.

/2009/ In 2009 we will complete a detailed, year-long statistical analysis comparing various cohorts of the mother with various results of births. This will be used in a number of ways, but the one most corresponding to HSI's 1A-2B is specifically the group of cohorts statistically significantly affecting, positively or negatively, the birth weight of the babies. //2009//

/2010/ ISDH completed the detailed statistical analysis comparing various cohorts (see 2009, above). The analysis of this year-long study is currently in process.//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.5	1.5	1.4	1.4	1.3
Numerator	1277	1336	1271	1258	
Denominator	87124	87088	89404	89835	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis.

Notes - 2006
Source of data: ISDH ERC.

Narrative:
These indicators will continue to be used as a monitoring tool, particularly for issues that others in ISDH or other agencies are taking the lead, (e.g. injury prevention and STDs). When appropriate, the statistics can also be used for evaluation.

Health Status Indicators 1A, 1B, 2A, and 2B -- low weight births, low weight singleton births, very low weight births, and very low weight singleton births -- directly provide information on that segment of Indiana's population. This supports a focus specifically on efforts to improve factors that contribute to low and very low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on these measures it serves as a monitoring tool for our programs, and allows us to evaluate the success of the programs involved. At present, despite very small numbers, the multi-year trend is overall trending down or stabilized.

/2009/ In 2009 we will complete a detailed, year-long statistical analysis comparing various cohorts of the mother with various results of births. This will be used in a number of ways, but the one most corresponding to HSI's 1A-2B is specifically the group of cohorts statistically significantly affecting, positively or negatively, the birth weight of the babies. //2009//

/2010/ ISDH completed the detailed statistical analysis comparing various cohorts (see 2009, above). The analysis of this year-long study is currently in process.//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.1	1.1	1.1	1.0	1
Numerator	937	963	959	898	
Denominator	84124	87088	89404	89835	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis.

Notes - 2006
Source of data: ISDH ERC.

Narrative:
These indicators will continue to be used as a monitoring tool, particularly for issues that others in ISDH or other agencies are taking the lead, (e.g. injury prevention and STDs). When appropriate, the statistics can also be used for evaluation.

Health Status Indicators 1A, 1B, 2A, and 2B -- low weight births, low weight singleton births, very low weight births, and very low weight singleton births -- directly provide information on that segment of Indiana's population. This supports a focus specifically on efforts to improve factors that contribute to low and very low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on these measures it serves as a monitoring tool for our programs, and allows us to evaluate the success of the programs involved. At present, despite very small numbers, the multi-year trend is overall trending down or stabilized.

/2009/ In 2009 we will complete a detailed, year-long statistical analysis comparing various cohorts of the mother with various results of births. This will be used in a number of ways, but the one most corresponding to HSI's 1A-2B is specifically the group of cohorts statistically significantly affecting, positively or negatively, the birth weight of the babies. //2009//

/2010/ ISDH completed the detailed statistical analysis comparing various cohorts (see 2009, above). The analysis of this year-long study is currently in process.//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	11.6	11.3	11.3	11.2	11.1
Numerator	154	150	147		
Denominator	1330543	1326607	1301093		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis.

Notes - 2006
Source of data: ISDH ERC.

Narrative:
Health Status Indicators 3A, 3B, and 3C -- the death rate per 100,000 from, respectively, unintentional injuries to children 14 and younger, unintentional injuries to children 14 and younger due to motor vehicle crashes, and unintentional injuries to children 15 - 24 due to motor vehicle crashes -- directly provide information related to child mortality, both in motor vehicle accidents, and due to overall unintentional injuries in the youngest segment of the population through age 14. This supports a focus on addressing causes of those fatal injuries and allows for targeted educational programs to encourage preventive behaviors, e.g., proper car seat use, proper seat belt use. It serves as a monitoring tool for the success of those programs, and allows us to evaluate those programs in terms of effect on the target populations. At present, the data on motor vehicle fatalities due to unintentional injuries is too varied to do a trend analysis, but the overall death rate from unintentional injuries to children age 14 and younger is trending down, with an unexplained drop in 2003; 2004 data continues the downward trend from 2002.

/2009/ In 2009 we will be looking into and doing analysis of the data from the last several years of mortality reports. We will also be be looking at death certificates which will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

/2010/ Due to the new Electronic Death Certificate being incorporated into the Indiana Data Store (IDS), formerly the ODS, analyses can be made which were not possible before. However, the IDS has not yet fully integrated the Hospital Discharge records needed to complete the analysis of non-fatal injuries. ISDH expects to be able to report more completely next year for HSIs 3B and 3C than in the past.//2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and	2004	2005	2006	2007	2008

Performance Data					
Annual Indicator	4.3	3.3	3.5	3.4	3.3
Numerator	57	44	46		
Denominator	1330543	1326607	1301093		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis.

Notes - 2006
Data Source: ISDH ERC

Narrative:
Health Status Indicators 3A, 3B, and 3C -- the death rate per 100,000 from, respectively, unintentional injuries to children 14 and younger, unintentional injuries to children 14 and younger due to motor vehicle crashes, and unintentional injuries to children 15 - 24 due to motor vehicle crashes -- directly provide information related to child mortality, both in motor vehicle accidents, and due to overall unintentional injuries in the youngest segment of the population through age 14. This supports a focus on addressing causes of those fatal injuries and allows for targeted educational programs to encourage preventive behaviors, e.g., proper car seat use, proper seat belt use. It serves as a monitoring tool for the success of those programs, and allows us to evaluate those programs in terms of effect on the target populations. At present, the data on motor vehicle fatalities due to unintentional injuries is too varied to do a trend analysis, but the overall death rate from unintentional injuries to children age 14 and younger is trending down, with an unexplained drop in 2003; 2004 data continues the downward trend from 2002.

/2009/ In 2009 we will be looking into and doing analysis of the data from the last several years of mortality reports. We will also be be looking at death certificates which will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

/2010/ Due to the new Electronic Death Certificate being incorporated into the Indiana Data Store (IDS), formerly the ODS, analyses can be made which were not possible before. However, the IDS has not yet fully integrated the Hospital Discharge records needed to complete the analysis of non-fatal injuries. ISDH expects to be able to report more completely next year for HSIs 3B and 3C than in the past.//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	29.8	26.2	25.9	25.9	25.6
Numerator	269	235	231		
Denominator	902179	897927	892372		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis.

Notes - 2006
Data Source: ISDH ERC

Narrative:
Health Status Indicators 3A, 3B, and 3C -- the death rate per 100,000 from, respectively, unintentional injuries to children 14 and younger, unintentional injuries to children 14 and younger due to motor vehicle crashes, and unintentional injuries to children 15 - 24 due to motor vehicle crashes -- directly provide information related to child mortality, both in motor vehicle accidents, and due to overall unintentional injuries in the youngest segment of the population through age 14. This supports a focus on addressing causes of those fatal injuries and allows for targeted educational programs to encourage preventive behaviours, e.g., proper car seat use, proper seat belt use. It serves as a monitoring tool for the success of those programs, and allows us to evaluate those programs in terms of effect on the target populations. At present, the data on motor vehicle fatalities due to unintentional injuries is too varied to do a trend analysis, but the overall death rate from unintentional injuries to children age 14 and younger is trending down, with an unexplained drop in 2003; 2004 data continues the downward trend from 2002.

/2009/ In 2009 we will be looking into and doing analysis of the data from the last several years of mortality reports. We will also be be looking at death certificates which will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

/2010/ Due to the new Electronic Death Certificate being incorporated into the Indiana Data Store (IDS), formerly the ODS, analyses can be made which were not possible before. However, the IDS has not yet fully integrated the Hospital Discharge records needed to complete the analysis of non-fatal injuries. ISDH expects to be able to report more completely next year for HSIs 3B and 3C than in the past.//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	114.1	118.2	112.6	110.3	107

Numerator	1518	1568	1465		
Denominator	1330543	1326607	1301093		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2006
Data Source: ISDH ERC

Narrative:
Health Status Indicators 4A, 4B, and 4C -- identical to 3A, 3B, and 3C, except as applied to nonfatal injuries -- directly provide much of the same information, support much of the same programmatic approaches, and also serve as a monitoring and evaluation tool as to the success of these approaches. The difference from HSI's 3A, 3B, and 3C is that success of the programs and approaches can be more reliably measured as the numbers of nonfatal injuries are greater than the numbers of fatal injuries. However, there are not enough years of data to establish a specific trend for HSI's 4A, 4B, and 4C at present. A few more data points, which will be collected over the next few years, will allow more detailed analysis.

/2009/ In 2009 we will be able to finish the study of injuries which was delayed due to personnel challenges. This will include several parts (see Youth Suicide for details from that perspective), but will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

/2010/ ISDH is continuing to work toward finishing the study of injuries begun in 2009 (see above) which combined with data from earlier years will move us toward being able to do more detailed analysis (see first paragraph above).//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	23.5	17.6	16.1	16	15.7
Numerator	313	233	210		
Denominator	1330543	1326607	1301093		
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2006
Source of data: ISDH ERC.

Narrative:
Health Status Indicators 4A, 4B, and 4C -- identical to 3A, 3B, and 3C, except as applied to nonfatal injuries -- directly provide much of the same information, support much of the same programmatic approaches, and also serve as a monitoring and evaluation tool as to the success of these approaches. The difference from HSI's 3A, 3B, and 3C is that success of the programs and approaches can be more reliably measured as the numbers of nonfatal injuries are greater than the numbers of fatal injuries. However, there are not enough years of data to establish a specific trend for HSI's 4A, 4B, and 4C at present. A few more data points, which will be collected over the next few years, will allow more detailed analysis.

/2009/ In 2009 we will be able to finish the study of injuries which was delayed due to personnel challenges. This will include several parts (see Youth Suicide for details from that perspective), but will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

/2010/ ISDH is continuing to work toward finishing the study of injuries begun in 2009 (see above) which combined with data from earlier years will move us toward being able to do more detailed analysis (see first paragraph above).//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	25.7	90.2	82.0	79.4	75.8
Numerator	232	810	732		
Denominator	902177	897927	892372		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2007
FY2007 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2006
Source of data: ISDH ERC.

Narrative:
Health Status Indicators 4A, 4B, and 4C -- identical to 3A, 3B, and 3C, except as applied to nonfatal injuries -- directly provide much of the same information, support much of the same programmatic approaches, and also serve as a monitoring and evaluation tool as to the success of these approaches. The difference from HSI's 3A, 3B, and 3C is that success of the programs and approaches can be more reliably measured as the numbers of nonfatal injuries are greater than the numbers of fatal injuries. However, there are not enough years of data to establish a specific trend for HSI's 4A, 4B, and 4C at present. A few more data points, which will be collected over the next few years, will allow more detailed analysis.

/2009/ In 2009 we will be able to finish the study of injuries which was delayed due to personnel challenges. This will include several parts (see Youth Suicide for details from that perspective), but will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

/2010/ ISDH is continuing to work toward finishing the study of injuries begun in 2009 (see above) which combined with data from earlier years will move us toward being able to do more detailed analysis (see first paragraph above).//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	26.6	26.8	26.2	26.9	26.3
Numerator	5797	5838	5805	5904	
Denominator	217646	217646	221589	219488	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH HIV/STD program, ISDH ERC

Notes - 2007
Source of data: ISDH HIV/STD program, ISDH ERC

Narrative:
Health Status Indicators 5A and 5B -- the rate per 1,000 women with a reported case of chlamydia among, respectively, women aged 15 through 19 and women aged 20 through 44 -- provides information related to one of the major sexually transmitted diseases in Indiana's women, both the teen-age and the young adult segment. This problem is growing among both populations. The upward trend supports the Indiana State Department of Health assigning a greater priority and more resources to combat this problem.

/2009/ In 2009 the prevelance of STDs in Indiana's population, and its continued growth, will be one of the major areas of focus for our Needs Assessment in order to discern the best strategies for being able to bring this down to the level of our sister states. While we will continue to run advertising, support programs based on abstinence education, and continue other items addressing this (see narrative section referencing Abstinence), we are studying this problem as it is one of our priority concerns. //2009//

/2010/ Indiana's prevelance of STDs remains a major focus of our efforts. While progress is being made at slowing the rate of growth which is more meaningful due to the increase in population, further efforts are warranted. This is a key factor in what will be our five-year Needs Assessment next year.//2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.4	8.2	8.4	8.5	8.6
Numerator	8056	8862	9018	9165	
Denominator	1083072	1083072	1076076	1078262	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
FY2008 data not yet available. Estimate provided based on trend analysis. Source of Data will be ISDH HIV/STD program, ISDH ERC.

Notes - 2007
Source of Data: ISDH HIV/STD program, ISDH ERC.

Notes - 2006
Source of Data: ISDH HIV/STD Program, ISDH ERC.

Narrative:
Health Status Indicators 5A and 5B -- the rate per 1,000 women with a reported case of chlamydia among, respectively, women aged 15 through 19 and women aged 20 through 44 -- provides information related to one of the major sexually transmitted diseases in Indiana's women, both the teen-age and the young adult segment. This problem is growing among both populations. The upward trend supports the Indiana State Department of Health assigning a greater priority and more resources to combat this problem.

/2009/ In 2009 the prevelance of STDs in Indiana's population, and its continued growth, will be one of the major areas of focus for our Needs Assessment in order to discern the best strategies for being able to bring this down to the level of our sister states. While we will continue to run advertising, support programs based on abstinence education, and continue other items addressing this (see narrative section referencing Abstinence), we are studying this problem as it is one of our priority concerns. //2009//

/2010/ Indiana's prevelance of STDs is a focus of our adolescent health efforts. While progress is being made at slowing the rate of growth which is more meaningful due to the increase in population, further efforts are warranted. This is a key factor in what will be our five-year Needs Assessment next year.//2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	88075	73702	10505	253	1451	0	2164	0
Children 1 through 4	349419	295267	38683	733	5413	0	9323	0
Children 5 through 9	434918	365925	49492	1246	6679	0	11576	0
Children 10 through 14	437919	371288	49824	1394	5693	0	9720	0
Children 15 through 19	452551	387968	50271	1530	5523	0	7259	0
Children 20 through 24	428771	370802	43446	1571	7576	0	5376	0
Children 0 through 24	2191653	1864952	242221	6727	32335	0	45418	0

Notes - 2010
Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Native Hawaiian or Other Pacific Islander included under "Asian".

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Native Hawaiian or Other Pacific Islander included under "Asian".

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Native Hawaiian or Other Pacific Islander included under "Asian".

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Native Hawaiian or Other Pacific Islander included under "Asian".

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Native Hawaiian or Other Pacific Islander included under "Asian".

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Native Hawaiian or Other Pacific Islander included under "Asian".

Narrative:
Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

/2009/ See section below 6A through 8B for further details. //2009//

/2010/ See section below 6A through 8B for further details. //2010//

Health Status Indicators 6A and 6B give total population by race, ethnicity, and age. This shows what segments of our population are experiencing the most growth and thus must be given more weight in programmatic terms. For example, Indiana is one of several states with an increasing Hispanic population. This knowledge helps us develop more multi-cultural programs, cultural awareness training, etc.

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

/2009/ In 2009, we are beginning the Needs Assessment process to determine how best to serve the people of Indiana. This of course means the demographic information from 6A and 6B will point us toward segments of population experiencing more need. The figures from 7A, 7B, 8A, and 8B will also provide us, when correlated with 6A&B, more details on which populations should be priority focus populations. In turn, this will guide our efforts to collect information related to addressing those priorities that have the most increased need based on demographics. To that end, we are developing statistical analyses, including trend analyses and various cohort analyses (see 1A through 2B for further details on this area of focus). //2009//

/2010/ The Needs Assessment process (see 2009 above) continue. The demographic information is proving useful at shaping the course of part of our research. Tools, analyses, and trends are continuing to be developed.//2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	79680	8395	0
Children 1 through 4	317429	31990	0
Children 5 through 9	401432	33486	0
Children 10 through 14	409674	28245	0
Children 15 through 19	428939	23612	0
Children 20 through 24	403747	25024	0
Children 0 through 24	2040901	150752	0

Notes - 2010
Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Narrative:
Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

/2009/ See section below 6A through 8B for further details. //2009//

/2010/ See section below 6A through 8B for further details. //2010//

Health Status Indicators 6A and 6B give total population by race, ethnicity, and age. This shows what segments of our population are experiencing the most growth and thus must be given more weight in programmatic terms. For example, Indiana is one of several states with an increasing Hispanic population. This knowledge helps us develop more multi-cultural programs, cultural awareness training, etc.

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

/2009/ In 2009, we are beginning the Needs Assessment process to determine how best to serve the people of Indiana. This of course means the demographic information from 6A and 6B will point us toward segments of population experiencing more need. The figures from 7A, 7B, 8A, and 8B will also provide us, when correlated with 6A&B, more details on which populations should be priority focus populations. In turn, this will guide our efforts to collect information related to addressing those priorities that have the most increased need based on demographics. To that end, we are developing statistical analyses, including trend analyses and various cohort analyses (see 1A through 2B for further details on this area of focus). //2009//

/2010/ The Needs Assessment process (see 2009 above) continues. The demographic information is proving useful at shaping the course of part of our research. Tools, analyses, and trends are continuing to be developed.//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	109	67	42	0	0	0	0	0
Women 15 through 17	2954	2242	674	3	3	4	18	10
Women 18 through 19	6977	5580	1312	12	16	17	28	12
Women 20 through 34	70564	61335	7486	94	1021	262	235	131
Women 35 or older	9094	7922	786	7	271	51	43	14
Women of all ages	89698	77146	10300	116	1311	334	324	167

Notes - 2010

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Narrative:

Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

Health Status Indicators 7A and 7B give us similar information, but specifically related to birth rates. This allows for us to specifically aim the multi-cultural programs and awareness toward pregnant women and newborn programs.

/2009/ See section below 6A through 8B for further details. //2009//

/2010/ See section below 6A through 8B for further details. //2010//

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

/2009/ In 2009, we are beginning the Needs Assessment process to determine how best to serve the people of Indiana. This of course means the demographic information from 6A and 6B will point us toward segments of population experiencing more need. The figures from 7A, 7B, 8A, and 8B will also provide us, when correlated with 6A&B, more details on which populations should be priority focus populations. In turn, this will guide our efforts to collect information related to addressing those priorities that have the most increased need based on demographics. To that end, we are developing statistical analyses, including trend analyses and various cohort analyses (see 1A through 2B for further details on this area of focus). //2009//

/2010/ The Needs Assessment process (see 2009 above) continues. The demographic information is proving useful at shaping the course of part of our research. Tools, analyses, and trends are continuing to be developed.//2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	91	18	0
Women 15 through 17	2518	425	11
Women 18 through 19	6251	712	14
Women 20 through 34	63608	6848	108
Women 35 or older	8288	785	21
Women of all ages	80756	8788	154

Notes - 2010
Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Narrative:
Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

Health Status Indicators 7A and 7B give us similar information, but specifically related to birth rates. This allows for us to specifically aim the multi-cultural programs and awareness toward pregnant women and newborn programs.

/2009/ See section below 6A through 8B for further details. //2009//

/2010/ See section below 6A through 8B for further details. //2010//

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

/2009/ In 2009, we are beginning the Needs Assessment process to determine how best to serve the people of Indiana. This of course means the demographic information from 6A and 6B will point us toward segments of population experiencing more need. The figures from 7A, 7B, 8A, and 8B will also provide us, when correlated with 6A&B, more details on which populations should be priority focus populations. In turn, this will guide our efforts to collect information related to addressing those priorities that have the most increased need based on demographics. To that end, we are developing statistical analyses, including trend analyses and various cohort analyses (see 1A through 2B for further details on this area of focus). //2009//

/2010/ The Needs Assessment process (see 2009 above) continues. The demographic information is proving useful at shaping the course of part of our research. Tools, analyses, and trends are continuing to be developed.//2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	671	494	162	0	1	1	9	4
Children 1 through 4	105	76	26	0	0	1	1	1
Children 5 through 9	62	50	11	0	0	1	0	0

Children 10 through 14	88	69	17	0	0	1	1	0
Children 15 through 19	304	255	46	0	0	1	2	0
Children 20 through 24	416	337	78	0	0	1	0	0
Children 0 through 24	1646	1281	340	0	1	6	13	5

Notes - 2010
Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

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Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Narrative:
Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

Health Status Indicators 8A and 8B give us similar information to 7A and 7B except that it is related to death data rather than birth data.

/2009/ See section below 6A through 8B for further details. //2009//

/2010/ See section below 6A through 8B for further details. //2010//

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

/2009/ In 2009, we are beginning the Needs Assessment process to determine how best to serve the people of Indiana. This of course means the demographic information from 6A and 6B will point us toward segments of population experiencing more need. The figures from 7A, 7B, 8A, and 8B will also provide us, when correlated with 6A&B, more details on which populations should be priority focus populations. In turn, this will guide our efforts to collect information related to addressing those priorities that have the most increased need based on demographics. To that end, we are developing statistical analyses, including trend analyses and various cohort analyses (see 1A through 2B for further details on this area of focus). //2009//

/2010/ The Needs Assessment process (see 2009 above) continues. The demographic information is proving useful at shaping the course of part of our research. Tools, analyses, and trends are continuing to be developed.//2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	612	59	0
Children 1 through 4	98	7	0
Children 5 through 9	56	6	0
Children 10 through 14	83	5	0
Children 15 through 19	291	13	0
Children 20 through 24	397	19	0
Children 0 through 24	1537	109	0

Notes - 2010

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data not yet available. 2007 data only available provisionally, not finalized.

Narrative:

Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

Health Status Indicators 8A and 8B give us similar information to 7A and 7B except that it is related to death data rather than birth data.

/2009/ See section below 6A through 8B for further details. //2009//

/2010/ See section below 6A through 8B for further details. //2010//

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

/2009/ In 2009, we are beginning the Needs Assessment process to determine how best to serve the people of Indiana. This of course means the demographic information from 6A and 6B will point us toward segments of population experiencing more need. The figures from 7A, 7B, 8A, and 8B will also provide us, when correlated with 6A&B, more details on which populations should be priority focus populations. In turn, this will guide our efforts to collect information related to addressing those priorities that have the most increased need based on demographics. To that end, we are developing statistical analyses, including trend analyses and various cohort analyses (see 1A through 2B for further details on this area of focus). //2009//

/2010/ The Needs Assessment process (see 2009 above) continue. The demographic information is proving useful at shaping the course of part of our research. Tools, analyses, and trends are continuing to be developed.//2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1792797	1494150	198775	5156	24759	0	69957	0	2007
Percent in household headed by single parent	33.4	28.8	66.9	0.0	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	4.9	2.7	2.2	0.0	0.0	0.0	0.0	0.1	2008
Number enrolled in Medicaid	684035	0	0	0	0	0	0	684035	2008
Number enrolled in SCHIP	33274	0	0	0	0	0	0	33274	2008
Number living in foster home care	12431	7728	4341	254	16	14	20	58	2008
Number enrolled in food stamp program	295928	190835	99310	494	1712	0	0	3577	2008
Number enrolled in WIC	202478	151862	37544	1434	2029	310	9277	22	2008
Rate (per 100,000) of juvenile crime arrests	1311.1	851.7	425.9	1.1	2.8	0.0	0.0	0.0	2008
Percentage	15.8	78.0	19.5	0.3	0.2	0.0	0.2	0.0	2007

of high school drop-outs (grade 9 through 12)									

Notes - 2010
Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Data for Medicaid not available yet by race/ethnicity. Expected to be available by late summer. Source of data: OMPP (Medicaid)

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Data for SCHIP not available yet by race/ethnicity. Expected to be available by late summer. Source of data: OMPP (Medicaid)

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

"More Than One Race" is included in "Other and Unknown" and has in the past been the majority of that category, but the data is not available to prove that with certainty.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: Indiana State Police, US Census Bureau. Ethnicity calculated based on overall population percentages, as ethnicity is treated as a race by ISP.

Source of data: 2007 data from Ann E. Casey "Kids Count" book, as initial 2008 data from IPS is being researched by IPS since it was inaccurate.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

The 15.8% is the total drop out rate. The demographics percentages are the percentages within that 15.8%, e.g., of the total drop-outs, 78% of them were white.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Narrative:
2008 racial breakdown data is unavailable; thus calculations have not yet been made to assign numbers to individual categories. That will be done when data is available.

Health Status Indicator 9 is the most diverse of the Health Status Indicators, encompassing racial and ethnic breakdowns among the following populations for children 0-19 years of age:

Percent in households headed by single parent
Percent in TANF (grant) families
Number enrolled in Medicaid
Number enrolled in SCHIP
Number living in foster home care
Number enrolled in food stamp program
Number enrolled in WIC
Rate per 100,000 of juvenile crime arrests
Percentage of high school dropouts, grades 9 through 12

Each one of these involves specific programs, some internal to ISDH and some external. We have some programs and some targets for the disparities revealed by these data. This allows for

monitoring results and evaluating what effect our programs have on these varying areas. Health Status Indicator 10 is the total of children ages 0 through 19 based on geographic living area. These areas are Metropolitan, Urban, Rural, and Frontier. Just over 2/3 of Indiana's children ages 0 through 19 live in urban areas, the vast majority of whom live in metropolitan areas. Just under 1/3 of Indiana's children ages 0 through 19 live in rural areas. Each living area represents unique challenges and benefits. For example, transportation to an adequate care facility may be more difficult in a rural area due to distance, whereas specific health problems (e.g., lead poisoning) may be more prevalent in a metropolitan setting due to a higher concentration of old housing with lead-based paint.

/2009/ It is impossible to address each of these components collectively, as they are completely separate and come from a wide range of sources including many from outside the agency's purview, and certainly outside agency control. Likewise, various of these items individually can only be impacted minimally by our efforts. However we can, and will, be effective in all of these areas to some degree via educational programs geared toward the population making up those varying demographic pieces (e.g., addressing several items via educational programs, advertisement, and services aimed at High School youth could have an impact on dropouts, juvenile crime, grant families, and tangentially other areas as well). We will continue the programs we have in place in 2009 while using data analysis to determine additional areas where our focus may have positive impact. //2009//

/2010/ As noted above, it is impossible to address each of these components collectively, as they are completely separate and come from a wide range of sources including many from outside the agency's purview, and certainly outside agency control. However we can be effective in these areas to some degree via educational programs (see 2009 above). We are continuing the programs in place in 2009 and gathering data to analyze for our five-year Needs Assessment.//2

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1637154	125728	0	2007
Percent in household headed by single parent	33.1	37.9	0.0	2008
Percent in TANF (Grant) families	0.5	0.4	0.0	2008
Number enrolled in Medicaid	0	0	684035	2008
Number enrolled in SCHIP	0	0	33274	2008
Number living in foster home care	11001	1022	408	2008
Number enrolled in food stamp program	292499	27436	3577	2008
Number enrolled in WIC	164519	37937	22	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	1311.0	2008
Percentage of high school drop-outs (grade 9 through 12)	92.6	7.4	0.0	2007

Notes - 2010
Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Data for Medicaid not available yet by race/ethnicity. Expected to be available by late summer.
Source of data: OMPP (Medicaid)

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Data for SCHIP not available yet by race/ethnicity. Expected to be available by late summer.
Source of data: OMPP (Medicaid)

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Source of data: Indiana State Police. The ISP is no longer even atempting to split out Hispanic (formerly they split it as a race). Therefore the data does not exist. Everyone is therefore reported as Ethnicity Not Reported.

Source of data: 2007 data from Ann E. Casey "Kids Count" book, as initial 2008 data from IPS is being researched by IPS since it was inaccurate.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

The demographics percentages are the percentages within the 15.8% overall, e.g., of the total drop-outs, approximately 7.4% were Hispanic

Source of data: US Census Bureau as well as ISDH ERC where applicable. 2008 data used where available, even if data were provisional. 2007 data used, even if data were provisional, where 2008 was not available.

Where break out was not possible, Native Hawaiian or other Pacific Islander are included with Asian.

Narrative:
Health Status Indicator 9 is the most diverse of the Health Status Indicators, encompassing racial and ethnic breakdowns among the following populations for children 0-19 years of age:

Percent in households headed by single parent
Percent in TANF (grant) families
Number enrolled in Medicaid
Number enrolled in SCHIP
Number living in foster home care
Number enrolled in food stamp program
Number enrolled in WIC
Rate per 100,000 of juvenile crime arrests
Percentage of high school dropouts, grades 9 through 12

Each one of these involves specific programs, some internal to ISDH and some external. We have some programs and some targets for the disparities revealed by these data. This allows for monitoring results and evaluating what effect our programs have on these varying areas. Health Status Indicator 10 is the total of children ages 0 through 19 based on geographic living area. These areas are Metropolitan, Urban, Rural, and Frontier. Just over 2/3 of Indiana's children ages 0 through 19 live in urban areas, the vast majority of whom live in metropolitan areas. Just under 1/3 of Indiana's children ages 0 through 19 live in rural areas. Each living area represents unique challenges and benefits. For example, transportation to an adequate care facility may be more difficult in a rural area due to distance, whereas specific health problems (e.g., lead poisoning) may be more prevalent in a metropolitan setting due to a higher concentration of old housing with lead-based paint.

/2009/ It is impossible to address each of these components collectively, as they are completely separate and come from a wide range of sources including many from outside the agency's purview, and certainly outside agency control. Likewise, various of these items individually can only be impacted minimally by our efforts. However we can, and will, be effective in all of these areas to some degree via educational programs geared toward the population making up those varying demographic pieces (e.g., addressing several items via educational programs, advertisement, and services aimed at High School youth could have an impact on dropouts, juvenile crime, grant families, and tangentially other areas as well). We will continue the programs we have in place in 2009 while using data analysis to determine additional areas where our focus may have positive impact. //2009//

/2010/ As noted above, it is impossible to address each of these components collectively, as they are completely separate and come from a wide range of sources including many

from outside the agency's purview, and certainly outside agency control. However we can be effective in these areas to some degree via educational programs (see 2009 above). We are continuing the programs in place in 2009 and gathering data to analyze for our five-year Needs Assessment.//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1270091
Living in urban areas	1229799
Living in rural areas	522052
Living in frontier areas	0
Total - all children 0 through 19	1751851

Notes - 2010

Narrative:
Health Status Indicator 10 is the total of children ages 0 through 19 based on geographic living area. These areas are Metropolitan, Urban, Rural, and Frontier. Just over 2/3 of Indiana's children ages 0 through 19 live in urban areas, the vast majority of whom live in metropolitan areas. Just under 1/3 of Indiana's children ages 0 through 19 live in rural areas. Each living area represents unique challenges and benefits. For example, transportation to an adequate care facility may be more difficult in a rural area due to distance, whereas specific health problems (e.g., lead poisoning) may be more prevalent in a metropolitan setting due to a higher concentration of old housing with lead-based paint.

/2010/ISDH is gathering geographic data as part of the five-year Needs Assessment as a cohort of multiple health status indicators and should be able for the first time to use the data from HSI 10 to assist in targeting specific programs to specific needs incorporating HSI 10's data.//2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	296450.0
Percent Below: 50% of poverty	5.2
100% of poverty	12.3
200% of poverty	30.5

Notes - 2010

Narrative:
Health Status Indicators 11 and 12 deal with the percentage of people living in poverty, 11 being for the entire state population percentage and 12 being the percentage of those 0 through 19 years of age in said condition. Again, as in Health Status Indicator 10, poverty reflects unique challenges, and the different conditions of poverty--50% of poverty level versus 100% of poverty level versus 200% of poverty level--call for different programmatic approaches. While the basic factor, money, is the core of what is involved, there is a significant difference in whether a mother

or child can pay for a service at all, even on a sliding scale, or whether that service has to be provided with no direct charge to the person served. The intent is to lower the number of persons living in poverty, but more specifically to raise those in extreme poverty to at least some level higher. Indiana has succeeded in lowering the percentage in the worst poverty category, which has caused some growth in the higher poverty level groups. By continuing to address the issues of health needs for all women and children in the state, and adding an additional focus as to the income aspect, it is anticipated that in the future all levels of poverty, from 200% of poverty level and lower, will decrease.

/2009/ This Health Status Indicator is very much reflective of the success of a variety of programs and as such can only be preipherally tied to ISDH efforts, yet is reflective of the success of those efforts. It is, however, the most tenuous of indicators, especially in the current housing/financial crises which have the capacity to overwhelm the poverty numbers no matter how successful any or all MCH programs are at lifting people out of poverty. In 2009, a close eye will be kept on everything that could impact this situation from a political, financial, and world perspective. By closely monitoring the effect outside forces are having, it may be possible to develop programs to mitigate some of the worst of the circumstances, which is exactly what we hope to do. //2009//

/2010/ ISDH continues to monitor (see 2009 above). Data is being gathered with poverty levels associated so that correlations can be made during analysis in conjunction with preparations for the five-year Needs Assessment.//2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1751851.0
Percent Below: 50% of poverty	7.5
100% of poverty	17.4
200% of poverty	39.0

Notes - 2010

Narrative:
Health Status Indicators 11 and 12 deal with the percentage of people living in poverty, 11 being for the entire state population percentage and 12 being the percentage of those 0 through 19 years of age in said condition. Again, as in Health Status Indicator 10, poverty reflects unique challenges, and the different conditions of poverty--50% of poverty level versus 100% of poverty level versus 200% of poverty level--call for different programmatic approaches. While the basic factor, money, is the core of what is involved, there is a significant difference in whether a mother or child can pay for a service at all, even on a sliding scale, or whether that service has to be provided with no direct charge to the person served. The intent is to lower the number of persons living in poverty, but more specifically to raise those in extreme poverty to at least some level higher. Indiana has succeeded in lowering the percentage in the worst poverty category, which has caused some growth in the higher poverty level groups. By continuing to address the issues of health needs for all women and children in the state, and adding an additional focus as to the income aspect, it is anticipated that in the future all levels of poverty, from 200% of poverty level and lower, will decrease.

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efforts. It is, however, the most tenuous of indicators, especially in the current housing/financial crises which have the capacity to overwhelm the poverty numbers no matter how successful any or all MCH programs are at lifting people out of poverty. In 2009, a close eye will be kept on everything that could impact this situation from a political, financial, and world perspective. By closely monitoring the effect outside forces are having, it may be possible to develop programs to mitigate some of the worst of the circumstances, which is exactly what we hope to do. //2009//

/2010/ ISDH continues to monitor (see 2009 above). Data is being gathered with poverty levels associated so that correlations can be made during analysis in conjunction with preparations for the five-year Needs Assessment.//2010//

F. Other Program Activities

The Indiana Family Helpline (IFHL) is designed to assist in promoting Maternal and Child Health Services, WIC and other programs and services throughout the state. In August 1992, the CSHCS Helpline merged with the IFHL to improve services to all Indiana families. During FY 2004, the IFHL responded to 18,828 calls and made 1,781 advocacy calls, resulting in 58,765 referrals./2008/During FY2006, the IFHL responded to 23,045 calls and made 2,183 advocacy calls resulting in 64,089 referrals.//2008///2009/ Approval has been received from the Health Commissioner for the IFHL to begin the process of becoming an IN211 call center and certification with the Association of Information and Referral Services (AIRS). Indiana 211 is a nonprofit organization and the goal is to create a seamless network of information and referral (I & R) services that enables anyone in Indiana in need of human services to have quick referrals to those who provide them by dialing 2-1-1. //2009///***2010/During FY2008, the IFHL responded to 26,550 calls and made 1,967 advocacy calls resulting in 65,824 referrals. IFHL continues to work toward AIRS certification.//2010//***

The Office of Cultural Diversity and Enrichment was created in March 2001 to help address the public health needs of minorities in Indiana. It was recognized that there was a need to place a stronger emphasis on cultural competency for health care professionals throughout the state, as well as all health care professional employees in the ISDH. On a yearly basis, the Office has conducted the Minority Health Disparity survey. The fifth annual assessment of cultural competence for ISDH contractors described in this plan was designed to continue efforts to improve the ability of contractors to meet the needs of Indiana minority populations in an effective, culturally competent manner. The assessment serves as the basis for requiring contractors to receive training on cultural competence until they demonstrate acceptable levels of performance. If current ISDH contractors demonstrate a continued inability to meet ISDH goals regarding effective, efficient, culturally competent programs, ISDH will seek alternate culturally competent contractors. In order to address the public health needs of Indiana minority groups, the Office of Cultural Diversity and Enrichment began offering a two-day Cultural Competence Workshop twice a month and a one-day Advanced Cultural Competency Workshop that is also held twice a month. To date, 1,300 health care professionals have attended these workshops. The two-day workshops emphasize cultural knowledge and cultural differences, strategies for working with racial/ethnic populations, the principles of interpreter services, and discussion of four different cultures (African American, Hispanic/Latino, Asian, Native American). The Advanced Workshops focus on dissimilarities in areas such as values, communication patterns, religion, beliefs, and health care professionals limited knowledge of other cultural groups. /2009/ This responsibility has now been moved to the Office of Minority Health. Workshops have been conducted at regional sites statewide //2009///***2010/The Indiana State Department of Health's (ISDH) Office of Minority Health (OMH) works on improving the health of Indiana's minority communities through increased awareness, partnerships, and the development and promotion of effective health policies, and culturally competent programs that serve to reduce minority health disparities. Some of the activities they have participated on***

include:1. Partnered with Health Evolutions to conduct an evaluation of Indiana's 95 local health departments to assess their capabilities to meet the increasing population expansion of Hispanics/Latinos. 2.Indiana State Department of Health is currently working to provide cultural competency training to 5 regional areas in the state and for its supervisors and mangers within the agency.//2010//

The Indiana Child Care Health Consultant Program was established in FY 2003 with the Family Social Services Administration - Bureau of Child Development providing dollars from the Child Care Development Fund, and Quality Initiatives Fund, to the State Department of Health to fund the project. The goal of the program is to increase the level of health and safety in out-of-home child care settings across Indiana through technical assistance and training for child care providers. The project provides another portal to services to increase the level of health and wellness that child care providers provide and the children they serve and their families need. Program staff includes a contracted Project Director, six regional child care health consultants, and a part-time support person. The regional child care health consultants are located in the field and coordinate with the numerous individuals and agencies currently involved with child care providers. There are four programmatic functions of the program. They include:
- Identification of licensed, registered, and license-exempt child care settings;
- Collection of data such as the child care settings' programs, health and safety practices, the immunization status and health insurance coverage status of the enrollees, back-to-sleep practices, accident occurrences, and the smoke-free status of the setting;
- Creation or identification and distribution of appropriate health and safety educational materials for use by child care providers and parents;
- Provision of consultation for child care providers around health and safety issues in out-of-home child care settings.

Another major component of the program is data collection and report generation. Documentation of the activities of the regional child care health consultants and the resulting changes in health and safety practices in out-of-home child care settings, and the change in health status of the children enrolled in the programs are two of the major foci. This program is currently being re-designed./2008/ In FY2006-2007 the focus shifted from state wide to three focus areas, Gary Indiana, Lawrence, Dubois, Spencer, and Perry Counties in Indiana. The consultants focused intensively of system development in these specific areas. Three ICCHC's conducted research with willing child care providers in these specific regions using a Health and Safety Assessment survey adapted from one used in California. They provided consultation on how to improve and are currently following up to assess improvement. //2008// /2009/ This program was transferred to the Bureau of Child Care in the Family and Social Services Administration. //2009//

In July 2003, the ISDH/MCSHC received a two-year grant from MCHB to fund the Indiana Early Childhood Comprehensive Systems (ECCS) Program. The program will create an integrated, coordinated, comprehensive system of services for children from birth to five. The coordinated system will support ease of access to needed services, increase the utilization of appropriate services and support the role of the family as their child's first teacher. This initiative will help to ensure that a holistic system of care supports young children and they arrive at school healthy and ready to learn. A Core Partner (steering committee) group was created to establish the Vision, Mission and Values of the program that provided the focus for the planning process The ECCS program staff, with ISDH technical staff assistance, established a website to promote public participation and facilitate communication across all committees.
The site can be found at http://www.in.gov/isdh/programs/mch/eccs/eccsindex.htm. The ECCS Project Director is working closely with other groups promoting healthy children and families that have been initiated by the Governor, Lt. Governor and federal grant opportunities to ensure the work is not being duplicated and that all the groups are communicating and moving forward together. The Implementation phase of the ECCS is scheduled to begin as the statewide strategic plan has been completed and submitted in May 2005 to the Maternal and Child Health Bureau./2007/The ECCS program has been renamed Sunny Start.//2007///2009/ The initiative

continues to impact the lives of children and families in the area of social emotional health with the development of a consensus statement regarding the content and core competencies for social-emotional training activities across all providers/caretakers of young children, birth to five. Sunny Start sponsored a comprehensive one week Summer Institute in July 2007.//2009///***2010/ Information updating Sunny Start may be found at http://sunnystart.in.gov/. To help families in the area of financial resources, Sunny Start developed informational documents which explain various programs like Medicaid. //2010//***

G. Technical Assistance

Title V 2005 Technical Assistance Request

Description of Technical Assistance Requested
Workshops are needed to address issues surrounding the fact that in Indiana the number of meth labs (Methamphetamine) found statewide has risen from 43 in 1998 to 1549 in 2004, with 15,994 meth labs found producing the drug nationally in 2004.

Reasons Why Assistance Needed
The greatest concentration of Meth Labs has been in the Midwest, and from 2003 to 2004, Indiana moved up the list of labs busted nationwide from sixth place to fourth place. As a result, children of families involved in Methamphetamine use and production in Indiana are disproportionately suffering from various forms of abuse and neglect.

What state, organization or Individual would you suggest providing the TA

Not known at this time

Description of Technical Assistance Requested

Domestic Violence is the leading cause of serious injury to women, more than rape, mugging and car crashes combined. Domestic Violence includes but is not limited to Physical, Sexual, Emotional, and Financial abuse.

Reasons Why Assistance Needed

The number one killer of pregnant women nationally is homicide. Technical assistance for MCH funded and Non-funded projects is desperately needed.

What state, organization or Individual would you suggest providing the TA

Indiana Coalition Against Domestic Violence

/2007/ Implementation of the Lung Associations Smoking and Pregnant Women cessation program training. Indiana ranks #1 among the 50 states as having the greatest number of women who smoke while pregnant. Training is available from the American Lung Association of Indiana which is a non-profit, dedicated to reducing the effects of Lung disease through education.

Prevention of child abuse. Indiana provides programs for professional, Medical staff, Families, and Adolescents. Statistically, Indiana ranks top five for child abuse. Training is available from Prevent Child Abuse Indiana, a non profit organization whose mission is to serve as a catalyst for preventing child abuse.//2007//

/2008/ Suicide is the 2nd leading cause of injury death in Indiana. In fact the state's rate has been higher than the national average for nearly a decade. The problem of suicide has an incredibly devastating effect on Hoosier families and communities--lost children, lost loved ones, lost

employees, and lost resources. These losses are preventable. In 2001, US Surgeon General, David Satcher, released a report entitled, "National Strategy for Suicide Prevention: Goals and Objectives for Action." This report described suicide as a serious public health problem throughout the United States and introduced a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM). The Surgeon General also recommended that each state adopt a suicide prevention plan that would incorporate the national recommendations.

In response to the national call to action and the magnitude of the problem in the state, the Indiana Suicide Prevention Coalition (ISPC) formed in 2001 to address this issue. Statewide workshops are needed to ensure that the MCSHC funded and Nonfunded network becomes familiar with Suicide's devasting effects on Hoosiers and the strategy for Suicide Prevention as outlined by the Surgeon General and the Indiana Suicide Prevention Coalition. //2008///2009/ Suicide remains as the second leading cause of death for Hoosiers ages 15 to 19, according to the Indiana Suicide Prevention Coalition. //2009///***2010/According to the May 8, 2009 Indianapolis Star Newspaper suicide rates have reached historic highs in Indiana and Indianapolis as the number of unemployed Hoosiers has risen. Statewide numbers are dated but in 2006, 815 suicides were reported in Indiana, the highest number in the past 25 years. In Indianapolis in 2008 153 suicides were reported by the Marion County coroner's office. Experts think the trend is showing no sign of abating this year, and it might be continuing upward as the unemployment numbers continue to reach historic heights in Indiana.There were 1,004 youth (ages 10-19) who were treated in an inpatient setting for attempted suicide or self-inflicted injury (15% of the total number of patients seen for self-inflicted injury during 2003-2005). The majority (80%) of the 1,004 attempts were made by youth 15-19 years old. The median age was 17 (range 10-19) with 68% of the attempts by females. Seventy-seven percent of all youth patients seen for self-inflicted injury were white, involving 68% white females and 32% white males. Blacks accounted for 9% of youth attempted suicides and other races accounted for 14% of all youth attempted suicides.(7)Emergency Room Data: The 2003-2005 hospital discharge dataset was reviewed for youth (ages 10-19) suicide attempts. Based on a query completed in the ED/outpatient center database, 2,530 youth patients attempted suicide or had injuries consistent with self-inflicted intentional injuries, which represented 28% of the total number of ED/outpatient center patients seen for self-inflicted injury. The majority (77%) of the 2,530 self-inflicted injuries were among youth 15-19 years old. The median age of attempted suicide was 16 (range 10-19) with 66% of the attempts made by females. More specifically, 80% of the attempts were made by youth of the white race, involving 66% white females and 34% white males. Blacks accounted for 6% of youth attempted suicide while other accounted for 14% of all youth attempted suicides.//2010//***

V. Budget Narrative

A. Expenditures

Annual Budget Expenditure Narrative
FY'05 Budget Expenditures

Indiana's FY 2003 cost-cutting measures included early retirement incentives, a personnel furlough program, and a statewide hire freeze. These programs were implemented for all state personnel positions, whether funded by state funds or other (Federal) funds. While these measures were not continued in FY 2004, the long-term impact still resulted in significant expenditure reductions for both state and Federal funds in FY 2005, as reflected on Form 3, Form 4, and Form 5.

As a result, ISDH MCSHC increased funding allocations to local projects. Additionally, MCSHC implemented a one-time program to fund infrastructure building and pilot projects at the local level. These projects were funded for one to three years.

In FY 2005, ISDH MCSHC began spending down the large carryover. By FY 2007, the remaining carryover will have been reduced from over 5 million to less than one million dollars./2008/For 2008, due to the movement of costs from Title V to the state CSHCN budget and the reduction of funding for grants, the MCH program was able to carry over $1.216 million dollars.//2008// //2009/The remaining carryover balance was reduced to $775K for 2008 and is projected to be a zero carry over going into 2009. In accordance with Finance's understanding of guidance received from HRSA, the budget figures for FY 2009 used on this application, starting with line 1 on Form 2, reflect the projected expenditures if current expenditure rates could be maintained. This figure ($14,210,461) exceeds the amount of the Federal allocation to Indiana actually anticipated ($11,779,106). //2009///***2010/ As projected no carryover in 2009 and no carryover is projected for FY2010. //2010//***

Maintenance of State Effort
In FY'89, Indiana's MCH Block Grant award was $10,527,556 and the State expended $11,539,520 in support of MCH activities. In FY'04 the MCH Block Grant award was $12,746,245 and the State expended $19,245,364 in support. In FY 2007 the MCH award is expected to be $11,890,921 and the State has available $39,092,884. State support includes money provided by state and local funds that MCSHC is authorized to spend on behalf of children with special health care needs. In FY 2004, MCHSC began counting the 30% match required of local projects as part of the Maintenance of State Effort. Line item expenditures for FY'89, FY'05 and budgeted amounts for FY'07 and FY08 are listed below:/2009/Additions to line item expenditures for 2007 and budgeted amount for 2009 are listed below.//2009///***2010/ Additions to line item expenditures for 2008 and budgeted for 2010 are listed below. //2010//***

State Funds
Expenditures in 1989
Expenditures in 2005
Expenditures in 2006
Expenditures in 2007
/2010/ Expenditures in 2008 //2010//
Budget for 2007
Budget for 2008
Budget for 2009
/2010/ Budget for 2010 //2010//

MCH Supplement
$193,223 expended in 1989
$0 expended in 2005

$0 expended in 2006
$0 expended in 2007
$176,700 expended for 2008
$0 budgeted for 2007
$0 budgeted for 2008
$176,700 budgeted for 2009
/2010/ $174,800 budgeted for 2010 //2010//
($176,700 was appropriated in both FY 2005 and FY 2007, but these funds are administratively withheld as a cost-cutting measure to address state budget shortfalls.)/2008/The state appropriation continues to be withheld.//2008///2009/The state appropriation was released and applied towards funding of two different grants.//2009///***/2010/ Appropriation was released and applied towards funding one grant for $176,700. For FY2010, $174,800 appropriated. //2010//***

Newborn Screening
$33,669 expended in 1989
$1,819,011 expended in 2005
$1,406,198 expended in 2006
$1,204,134 expended in 2007
/2010/ $1,478,014 expended for 2008 //2010//
$1,224,126 budgeted for 2007
$1,360,958 budgeted for 2008
$1,360,958 budgeted for 2009
/2010/ $2,448,712 budgeted for 2010 //2010//
(This program is funded by a provider fee for each newborn screened. This fee was increased from $7.50 to $30.00 in 2004.)

Children with Special Health Care Needs
$11,312,628 expended in 1989
$10,508,873 expended in 2005
$13,812,256 expended in 2006
$16,392,075 expended in 2007
/2010/ $12,939,439 expended in 2008 //2010//
$31,675,974 budgeted for 2007
$28,591,740 budgeted for 2008
$16,760,542 budgeted for 2009
/2010/ $13,862,040 budgeted for 2010 //2010//
(ISDH has seen an increase in projected revenue for State Children's Special Health Services funds. These are partially funded by county revenue that increased as a result of an increase in assessed property values. The budgeted amount includes carryover funds and reflects the balance in the dedicated account. These funds are dedicated to the CSHCS program to pay for covered health care for CSHCN. Funds available for FY 2007 will not all be used.)/2008/Revenue for 2008 has been projected as a decrease based on a state appropriation reduction from an anticipated $5.9 million to $1.7 million.//2008// /2009/Additionally, in 2008 another $850K was withheld from the State appropriation. Property Taxes were restructured, causing a delay in receipt of revenues for the year. Indiana is in a transition period of moving the source of State CSHCN funding from property taxes to a general appropriation. //2009/***/2010/ CSHCS Program will be funded by a portion of the Title V block grant and state appropriations only. Previously, the CSHCS Program was funded by property tax levies, but that source of funding has been eliminated. The amount of funding through state appropriations, though originally intended to approximate the amount from property tax levies, depend on the governor's recommendation and the legislature's vote on the budget bill. FY 2010 state appropriations are $13.8 million, a decrease from the prior year. Of that amount 8% is held back and actual funding is $12.69 million. //2010//***

TDAB Meconium Screening
$0 expended in 1989
$59,371 expended in 2005
$55,840 expended in 2006
$58,121 expended in 2007
/2010/ $59,371 expended in 2008 //2010//
$62,496 budgeted for 2007
$61,246 budgeted for 2008
$62,496 budgeted for 2009
/2010/ $58,121 budgeted for 2010 //2010//

RESPECT (State sexual abstinence education)
$0 expended in 1989
$520,866 expended in 2005
$509,809 expended in 2006
$438,381 expended in 2007
/2010/ $523,554 expended in 2008 //2010//
$596,280 budgeted for 2007
$554,540 budgeted for 2008
$554,500 budgeted for 2009
/2010/ $494,872 budgeted for 2010 //2010//

TPSUPP (Prenatal Substance Use Prevention - State Tobacco Settlement Funds)
$0 expended in 1989
$181,899 expended in 2005
$120,270 expended in 2006
$91,045 expended in 2007
/2010/ $139,500 expended in 2008 //2010//
$153,333 budgeted for 2007
$147,000 budgeted for 2008
$150,000 budgeted for 2009
/2010/ $132,000 budgeted for 2010 //2010//

Local MCH Appropriations
(Municipal and County appropriations used by local MCH grantees as matching funds)
$0 expended in 1989
$674,567 expended in 2005
$1,119,588 expended in 2006
$1,568,926 expended in 2007
/2010/ $1,134,736 expended in 2008 //2010//
$753,805 budgeted for 2007
$1,172,528 budgeted for 2008
$1,146,380 budgeted for 2009
/2010/ $412,179 budgeted for 2010 //2010//

Other Matching Funds
(Funds from sources other than local appropriations and income used by local MCH grantees as matching funds)
$0 expended in 1989
$3,050,850 expended in 2005
$1,667,081 expended in 2006
$1,572,421 expended in 2007
/2010/ $2,874,550 expended in 2008 //2010//

$2,620,339 budgeted for 2007
$2,874,550 budgeted for 2008
$3,076,071 budgeted for 2009
/2010/ $3,269,680 budgeted for 2010 //2010//

Program Income
(Income from Medicaid, patient fees, insurance and donations used by local MCH grantees as matching funds)
$0 expended in 1989
$2,990,665 expended in 2005
$3,050,389 expended in 2006
$2,446,299 expended in 2007
/2010/ $2,111,508 expended in 2008 //2010//
$2,006,531 budgeted for 2007
$2,473,958 budgeted for 2008
$2,586,655 budgeted for 2009
/2010/ $2,831,064 budgeted for 2010 //2010//

TOTAL
$11,539,520 expended in 1989
$19,806,102 expended in 2005
$32,132,370 expended in 2006
$40,084,803 expended in 2007
/2010/ $34,565,631 expended in 2008 //2010//
$39,092,884 budgeted for 2007 (Funds available for FY 2007 will not all be used.)
$44,902,793 budgeted for 2008
$43,048,193 budgeted for 2009
/2010/ $36,196,159 budgeted for 2010 //2010//

FY'05 Unobligated Funds
Despite growing expenses and decreasing federal Title V awards, the large unobligated balance carried over from FY 2004 remained large coming into FY 2005.

In FY 2004, ISDH allowed ongoing MCH projects to apply for a 10% increase in requested funds to take into account previous flat-line allocations. Further, ISDH has implemented a one-time, short-term grant program to build infrastructure throughout the state. Additionally, Title V funds are now called upon to support allowable programs previously supported by funds such as the Preventive Health and Health Services Block Grant that are no longer available. This significantly reduced carryover amounts for FY 2005 through FY 2007. The projected carryover into FY 2007 will be $951,353./2008/The carry-over is $1.216 million as a result of effective budgeting and controlling expenditures, most effectively.//2008///2009/There is no projected carry-over of funds for FY09.//2009//***/2010/ No carryover projected for FY2010 //2010//***.

Indiana operates its program on a first in first out basis; therefore the unobligated carryover will be expended first.

B. Budget

Annual Budget and Budget Justification

FY'09 Summary Budget

Component A: Services for Pregnant Women, Mothers, and Infants up to age one.
Component B: Preventive and Primary Care Services for Child and Adolescents.
Component C: Family-Centered, Community-Based, Coordinated Care and the development of Community-Based Systems of Care for Children with Special Health Care Needs and their

Families.
Administrative Costs: Indirect Costs

Dollars | Percentages

/2010/ Component A $3,666,529| 31.13% //2010//
/2010/ Component B $3,609,321| 30.64 % //2010//
/2010/ Component C $3,829,800| 32.51% //2010//
/2010/ Administrative Cost $ 673,456| 5.72% //2010//
/2010/ Grant Total $11,779,106| 100.00% //2010//

I. Direct Medical Care Services
The $19,530,717 budgeted at this level include all community grants that provide direct services and projected medical claims for CSHCN and hemophilia premiums./2008/FY2006 $14,199,521 was expended for Direct Care; $14,973,082 and $16,340,115 for 2007 and 2008 are budgeted, respectively.//2008///2009/ Actually expended $13,019,914 for FY 2007; budgeted $17,805,732 for FY 2009.//2009//FY2008 ***/2010/ expended $16,843,345; budgeted $5,688,485 FY2010 //2010//***

II. Enabling Services
The $24,050,864 budgeted at this level include all community grants that provide enabling services and all other CSHCS state funds not projected for direct medical care services./2008/FY2006, $8,175,574 was expended for Enabling Services; $25,791,692 and $16,943,524 are budgeted for FY2007 and FY 2008 respectively.//2008// /2009/Actually expended $13,702,289 for FY 2007 and budgeted $10,676,564 for FY 2009.//2009//***/2010/ expended $11,489,283; budgeted $17,447,119 FY2010 //2010//***

III. Population Based Services
The $3,935,733 budgeted at this level include all community grants that will provide population based services, Newborn Screening funds, and Indiana RESPECT funds./2008/FY2006, $4,017,739 was expended for Population Based Services; $4,664,006 and $4,237,716 are budgeted FY 2007 and FY2008 respectively.//2008///2009/Actually expended $3,008,030 for FY2007 and budgeted $3,793,473 for FY 2009.//2009//***/2010/ expended $2,461,002; budgeted $5,622,458 FY2010 //2010//***

IV. Infrastructure Building Services
The $8,433,775 budgeted at this level include salaries of all staff and other operating expenses (minus insurance premiums and community grant funds), the statewide needs assessment, data systems, and the Indiana Perinatal Network./2008/FY2006, $5,739,536 was expended for Infrastructure Building Services.//2008///2009/Actually expended $6,596,854 for FY2007 and budgeted $7,809,034 for FY2009.//2009//***/2010/ expended $3,771,001; budgeted $7,381,097 FY2010 //2010//***

/2010/ Total FY 2008 budget is $44,902,793 and expended $34,564,631. //2010//

3.3.1 Completion of Budget Forms
See forms 3, 4, and 5.

3.3.2 Other Requirements
Maintenance of State Effort -- See comparisons of FY 1989 and FY 2005 expenditures and FY 2007 budget in previous section.

FY'07 Unobligated Funds
The projected unobligated balance for FY 2007 is $951,553, which reflects a significant decrease from the unobligated balance for FY 2006. ISDH structured costs for this program have grown while federal allocations have been reduced. As a result, ISDH MCSHC has had to reduce local

MCH grants from a high of 8.5 million to less than 6.5 million dollars./2009/For FY2009 there are no carryover funds and grants will be reduced to under 5 million dollars. The budget figures for FY2009 used on this application starting with line 1 on form 2 reflect the projected expenditures if current expenditure rates could be maintained. This figure ($14,210,461) exceeds the amount of the Federal allocation to Indiana actually anticipated ($11,779,106).//2009//

Carryover grew from FY 2001 through FY 2005 as a result of tightened state spending during FY 2002 through FY 2004. ISDH MCSHC took a number of steps to use these savings to build infrastructure throughout the state. Ongoing MCH project allocations were increased by nearly a million dollars from FY 2003 to FY 2004 and an additional one-time, short-term grant program was developed that obligated an additional $1,034,858 in FY 2005 and was designed to grant out up to an additional million dollars each year during FY 2006 and 2007. These short-term, one-time grants were primarily targeted to conducting Fetal Infant Mortality Reviews, community-based needs assessment and other infrastructure building projects.

Additionally Title V funds are being called upon to provide additional support for projects previously funded by funds no longer available such as the Preventive Health and Health Services Block Grant. This included a $335,000 grant to the Indiana Poison Control Call Center. Alternative funding is being sought for these expenditures.

Due to reduced available funding, MCSHC has to go from approximately $8.5 million in local grants down to less than $6.5 million. In addition, the new Medicaid eligibility requirements may increase the non-paying clients prenatal and child health clients served by local MCH projects. As a result, MCSHC is reducing grants to most existing local MCH projects by 6% to 9% from FY 2006 funding levels. Additionally, MCHSC is reducing or terminating a number of Special Projects that were projected to be funded for FY 2007. Also, some new projects that have been approved will not be funded until funds become available. This will enable MCSHC to maintain as broad array of services to as large a population as possible and achieve the broadest healthy maternal, birth and child health outcomes with a minimal disruption in services.

To improve budget flexibility to provide maximum services to the MCH population, ISDH MCSHC is requesting a waiver for FY 2007 to allow Title V expenditures for CSHCN to be less than 30% of total Title V expenditures./2008/MCH took steps to request the waiver but clarification by MCHB pointed out that States had additional flexibility in allocating expenditures. With this additional flexibility MCH met the 30%.//2008//
/2009/For FY2009, due to reduced available funding, MCH has projected a reduction in local grants down to approximately $5 million. The budget figures for FY2009 used on this application starting with line 1 on form 2 reflect the projected expenditures if current expenditure rates could be maintained. This figure ($14,210,461) exceeds the amount of the Federal allocation to Indiana actually anticipated ($11,779,106).//2009//

MCSHC has traditionally met the 30% requirement for expenditures related to CSHCN by using Title V funds to pay for staff who administer the State-funded CSHCN program and by funding local initiatives serving CSHCN. Indiana has a unique State-funded program to pay for services for CSHCN. This program expends more than $10 million annually. The State CSHCN program has sufficient State funds to support the CHSCN initiatives currently funded by Title V while remaining self-supporting. By transferring a greater responsibility for these costs to the State CSHCN funds, MCSHC could make more funds available for programs to ensure healthy birth outcomes. ***/2010/ Because of budget decreases, grants totaling $1.6 M previously supported financially by CSHCS state funds have been moved to Title V.//2010//***

Indirect Cost Rate Agreement
The rates listed below and approved in the Rate Agreement between ISDH and DHHS are for use on grants, contracts, and other agreements with the Federal Government subject to the conditions in Section III. It should be noted that Indiana considers indirect costs to be the administrative costs of the programs.

SECTION I: INDIRECT COSTS RATES*
RATETYPES FIXED FINAL PROV.(PROVISIONAL)

PRED.(PREDETERMINED)EFFECTIVEPERIOD
TYPES FROM TO RATES(%) LOCATIONS APPLICABLE
FIXED 07/01/05 06/30/06 7.0 All All Programs
PROV 07/01/06 until amended 11.5 All Programs

*Based:
Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations), sub-awards and flow-through funds. 11.5 is the maximum rate currently projected for FY'07.
/2009/The rate during FY2008 was 14.2, but has dropped to 11.8 on July 1, 2008.//2009//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.